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CIS

MEDICARE CATASTROPHIC COVERAGE ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON RETIREMENT INCOME AND EMPLOYMENT

OF THE

SELECT COMMITTEE ON AGING HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MARCH 6, 1989, CEDAR RAPIDS, IA

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CONTENTS

MEMBERS OPENING STATEMENTS

Page

Chairman Thomas J. Tauke 1

Harris W. Fawell 8

CHRONOLOGICAL LIST OF WITNESSES

Joe L. Tilghman, Deputy Region VII Administrator, Health Care Financing Administration, Department of Health & Human Services 15

Allen Johnston, Director of Member Relations and National Grassroots Action, the National Committee to Preserve Social Security and Medicare.... 22

Cliff Humphrey, Vice-President, Iowa State Council of Senior Citizens 38

Lonnie Conger, President, State of Iowa Chapter of the National Association for Retired Federal Employees 39

Shirley Henderson, Senior Advocate, Heritage Area Agency on Aging 47

Joe Rodecap, Chairman of the Iowa Social Security Notch Group, Des Moines, IA 49

Beulah Rodecap, Iowa Committee to Correct Inequities in Social Security and Medicare Des Moines, IA 51

Joe Bolkcom, Director, Linn County Senior Advocates 53

AUDIENCE PARTICIPANTS

Paul Jaucer, Des Moines, IA 61

Ann Kubatz, Cedar Rapids, IA 61

Betty Dales, Grinnell, IA 61

Leo Morrisey, Cedar Rapids, IA 62

Gretchen Walder, Seniors of the Coalition Against the Catastrophic Act 62

Otto Mueller, Cedar Rapids, IA 62

Dorothy Conner 63

Gordon Martin, Mt. Vernon, IA 64

Jean Jensen, Anamosa, IA 65

Lionel Patterson, Cedar Rapids, IA 68

Lloyd Jevanson, Coralville, IA 69

Howard Silverman, Wyoming, IA 70

Harold Needham, El Gator, IA 71

Lauren Peete, Cedar Rapids, IA 72

George Evans, Marion, IA 73

Maureen Tittler, Albernette, IA 73

Mary Polance, Cedar Rapids, IA 74

Willard Clay, Cedar Rapids, IA 75

George Clane, Dubuque, IA 76

MEDICARE CATASTROPHIC COVERAGE ACT

MONDAY, MARCH 6, 1989

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON RETIREMENT INCOME AND EMPLOYMENT,
Cedar Rapids, IA.

The subcommittee met, pursuant to notice at 9:04 a.m., in the Auditorium of Teamsters Hall, 5000 J St, SW, Cedar Rapids, Iowa, Hon. Tom Tauke (acting chairman of the committee) presiding.

Members present: Representatives Tauke and Fawell.

OPENING STATEMENT OF CHAIRMAN THOMAS J. TAUKE

Mr. TAUKE. Ladies and gentlemen, I want to welcome you to our hearing this morning of the Select Committee on Aging, Subcommittee on Retirement Income and Employment, of the House of Representatives. Not only am I pleased to welcome all of you here to this hearing this morning, but I also want to welcome my colleague from the great State of Illinois, Harris Fawell. Harris and I serve together not only on the Aging Committee but also on the Education and Labor Committee, and so we have an opportunity to spend a lot of time in the same room with one another and he still likes me; we still get along. I have had the opportunity to watch him work very closely on this particular issue which we will discuss this morning and he has become a real leader in the House of Representatives on the Catastrophic Health Insurance issue.

I believe that it is important that we just take a moment to run through the procedures that we will follow this morning. For those of you who have not been to a subcommittee hearing before let me just tell you that we usually follow the procedure that we will have today. First we will ask a number of witnesses who have prepared testimony to go forward to this table here and deliver their testimony to the subcommittee. We will then, Congressman Fawell and I, will have an opportunity to ask those witnesses questions. Then after all of those witnesses have testified we will open up the microphone which is in the center of the auditorium to people from the audience who wish to offer comments or observations.

Our hope is that we will be able to wrap this up by about 12:15 today and have an opportunity to visit with some of you informally for a few moments after that.

I might observe that there is coffee over here to my left for those of you who would like to have coffee; restrooms are in the back and if anybody has any questions or needs any assistance, several members of my staff are—would you raise your hands—are here to offer assistance to anybody who needs help.

There's some handout materials over at the table at the entrance to the hallway. Those materials include some information about the Catastrophic Health Insurance program which may help clarify any of the concerns that any individuals have.

Over the past several months, as individuals have obtained information about the coverage provided under the Catastrophic Coverage Act and how that coverage has been financed, members of Congress have been flooded with letters and calls from the elderly outlining the serious flaws that they see in the new law. To date, for example, I have received hundreds of letters in opposition to the Catastrophic Bill; I have received only two letters supporting the new law. I have received hundreds of calls from individuals seeking repeal or changes in the law.

We have convened this hearing of the Retirement Income Subcommittee for several reasons. First, we wish to ensure that the new law is fully understood. Second, we wish to explore its impact on the elderly. Third, we wish to explore options for addressing the concerns that individuals have with this new legislation. We will share the record of today's hearing with our colleagues in Congress, and we hope that the record of this hearing will spur consideration of legislation that has been introduced to repeal or to change the law and to provide some background for those deliberations.

As many of you know, I voted against the Medicare Catastrophic Coverage Act when it was before Congress. But that vote was not an easy vote. I strongly supported many of the provisions of the law, including those which offered our senior citizens protection against catastrophic medical expenses. I think it's fair to say that nobody should be forced into poverty to pay for health care, and no one should be forced to choose between filling a prescription and having enough to eat that week. Elderly couples should not be forced into poverty before Medicaid will assist them with nursing home bills. And that is why I wrote and sponsored the amendment to provide the spousal impoverishment protection provisions of this legislation when it was before the Health Subcommittee. So there are good things in the legislation.

And the new law is clearly well-intended. But it seems to me that the new law has significant problems. And the bottom line problem is that the costs, in my judgment, are greater than the benefits received. The cost to senior citizens is very substantial, particularly to middle income senior citizens. The benefits received by those same senior citizens are in many cases very minimal.

There are two fundamental flaws that I see with the legislation. The first flaw has to deal with the way in which we handled retirement income plans for those senior citizens who already had health care coverage through their retirement program. Let's say an individual works at John Deere or Quaker Oats or Rockwell International and retires. Generally they have a retirement plan which includes a fairly substantial health care package. That health care package plus Medicare generally provides those individuals with all of the health care insurance coverage they desire. Yet those individuals under this legislation must still pay, in some cases up to $1,500 or $1,600 for the coverage provided in the Catastrophic Health Insurance Act. They had to pay for that coverage despite the fact that they were getting very little, if anything, in additional benefits. Well what happens to the coverage that they were receiving from Rockwell or Quaker Oats or John Deere? Well, the bottom line is Rockwell, Quaker Oats or John Deere are let off the hook for the promises they had made to those senior citizens. So those major corporations have some of their promises relieved while senior citizens have to pay the bill to pick up the tab, to fill in the gaps. That's one of the reason why this hasn't been a good deal for senior citizens.

The second big reason that it hasn't been a good deal, it seems to me, is because of the pool that is created by this bill, the insurance pool. It includes all senior citizens but it also includes all the disabled. Now I think everybody would agree that we ought to ensure that the disabled have access to catastrophic health care coverage; there's no dispute about that. But certainly I think we could also all agree that senior citizens aren't the ones who should have to pick up the tab for that care for the disabled. But that's what happens under this legislation; the cost of providing catastrophic care for the disabled is picked up by senior citizens and senior citizens alone. That is a cost that should be borne by society as a whole, not just by the elderly population in our society.

So I think those two fundamental reasons are the reasons why it's not a good deal: The costs are higher for senior citizens than the benefits received.

There is a related issue, too, which I have been focusing some attention on the last few weeks and which this chart you see up here focuses on. And that is that this legislation combined with a number of other pieces of legislation that are on the books create a very strange tax problem for senior citizens. The elderly of our society now face the highest marginal tax rates ever imposed on middle-income taxpayers in the country. The National Thunder for Policy Analysis recently did a study of what's happening to senior citizens. What they found is that senior citizens in the $20,000 to $30,000 income range in some cases have marginal tax rates of over 100 percent. In other words, if a senior citizen earns an extra dollar they can actually end up having to pay $1.02 in taxes. Now admittedly this happens to only a small number of senior citizens, but essentially what occurs is this: If the senior citizen earns a dollar, if they earn a dollar they lose .50 in Social Security benefits; then by the time they pay their Medicare costs, their Social Security taxes, their Federal Income Taxes, their State Income Taxes, they actually are paying almost all of that dollar or in some cases more than that, in additional taxes.

Now the Catastrophic Health Insurance package is only a part of that problem, but it highlights, I think, what is becoming a very serious problem for many senior citizens who do have an income. And that is that as they earn additional dollars virtually all of it goes to taxation. So that is an issue, too, which needs to be focused on as we discuss this legislation.

The questions before us today then are: First, what should we do about the current catastrophic coverage law? Secondly, if we change that law, what kind of catastrophic insurance coverage should we offer to senior citizens?

I am looking forward to the testimony to be presented this morning and to the comments of the audience. Thank you very much.

[Material submitted for the hearing record by Mr. Tauke follows:]

Information And Analysis Of The Medicare Catastrophic Coverage Program

Compiled By Rep. Tom Tauke

Vice Chairman

Subcommittee On Retirement Income and Employment

Of The

U.S. House Select Committee On Aging

March 1989

Overview of the New

Medicare Catastrophic Coverage Program

How Medicare Coverage Changed. How Many People Will Benefit.

Type of Service	Former Plan	New Plan	Coverage Limits
Hospital	Patient paid first $540 for each hospital stay. Medicare paid first 60 days in full, part of days 61-90, nothing after.	Patient pays part of first hospital stay ($564 in 1989). Thereafter, Medicare covers unlimited days in full.	Less than 1% of senior citizens experience extended hospital stays and therefore would benefit from more coverage.
Skilled Nursing Care	Medicare paid first 20 days in full. Patient paid $67.50 a day for days 21-100 and full cost thereafter.	Patient pays $25.50 a day for first 8 days. Medicare pays days 9-150 in full. Patient pays full cost thereafter	New plan still does not cover long-term or "intermediate" nursing home care.
Doctor, Outpatient Care	Medicare paid 80% of "approved" amount after patient paid first $75.	Same, except Medicare pays 100% of "approved amount" after patient has paid $1,370 in a year (higher in subsequent years). Patient still responsible for charges above the Medicare approved amount.	If more than 7% of eligible beneficiaries apply for benefits in one year, deductible paid by seniors is increased the following year.
Prescription Drugs **(Intravenous and organ transplant drugs have separate coverage)**	No coverage.	No coverage in 1989-90. In 1991, patient pays first $600, Medicare pays 50% thereafter. In years after, patient's first-payment rises above $600, Medicare's share rises to 60% in 1992 and 80% in 1993.	If more than 17% of eligible beneficiaries apply for benefits in one year, deductible paid by seniors is increased the following year.

Who Pays For The New Medicare Coverage, And How Much

Benefits are financed through 1) a new income tax surcharge on senior citizens and 2) increases in Part B premiums.

New Tax All senior citizens will be subject to a surcharge based on how much income tax they pay. For each $150 of federal tax paid, the surcharge will be:

1989	1990	1991	1992	1993
$22.50	$37.50	$39.00	$40.50	$42.00

The surcharge is capped at $800 per beneficiary in 1989 and $1,050 in 1993. Thus, an elderly couple could pay as much as a $2,100 surcharge.

About half of all senior citizens have enough income to pay income tax and therefore must pay a tax surcharge. Researchers estimate that, of those who must pay, the average annual surcharge will be $355 in 1989, rising to $630 in 1993.

Premium Increase In addition to the tax surcharge, the new benefits will be financed through increases in the Part B premium. Nearly all (97 percent) of senior citizens pay this premium.

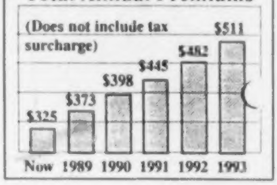
The chart below illustrates how much seniors will pay for the premium each year over the next five years. In 1993, a single senior will pay more than $500 and a couple will pay more than $1,000.

Paying The New Medicare Bill: Examples

In 1993, the Medicare surcharge will be 28 cents on each tax dollar paid. The Part B premium will be $511 per person. Therefore, for that year:

- A single senior with $12,000 of taxable income will pay about $1,050 in income tax. Thus this person will pay a $294 surcharge (0.28 x $1,050). When adding the $511 premium, this person will pay a grand total of more than $800.
- A couple with $25,500 in taxable income will pay $2,250 in taxes plus a $630 Medicare surcharge (0.28 x $2,250). Adding the premium paid by both, the couple will pay $1,652 for their Medicare coverage.

Total Annual Premiums



Findings of the National Center For Policy Analysis (NCPA):

Elderly Now Face Highest Marginal Tax Rates Ever Imposed On Middle Income Taxpayers

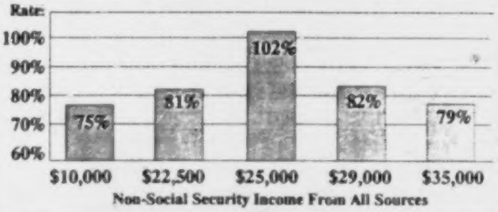
Quotes from NPCA study

- While marginal tax rates were reduced dramatically for the non-elderly in the 1980's, the increase in marginal rates for middle-class elderly workers has been equally dramatic.
- Some elderly employees are facing 1989 marginal tax rates as high as 102% -- they will lose $1.02 for each $1 they earn.
- For elderly taxpayers earning the minimum wage, the Medicare surtax can be as high as 6.3% for each additional dollar of income. In 1993, when the surtax reaches 28% of income taxes, elderly taxpayers earning the minimum wage will face a Medicare surtax as high as 11.76% of each additional dollar of income.
- Taxes are regressive. Once taxpayers reach the cap on the Medicare surtax ($800 per person in 1989), the taxes become an increasingly smaller proportion of income as income rises.

Definition Of Marginal Tax Rate

An "effective marginal tax rate" measures the income reduction workers experience when they earn one more dollar of wages. The reduction includes payment of all taxes on income. For the elderly, this includes the Social Security benefit tax and the Medicare surtax, in addition to regular income taxes and payroll taxes.

Effective Marginal Tax Rate
On Wages For Elderly Individuals Earning $8,880



Comparison of Effective Marginal Tax Rates:
Elderly And Non-Elderly Workers

Workers Earning Less Than $8,880

Income Tax Bracket	Marginal Rates:Elderly	Marginal Rates: Non-Elderly	Difference In Tax Rate On The Elderly
15% Bracket	33.39%	22.51%	+10.88%
28% Bracket	55.81%	35.51%	+20.30%

Workers Earning More Than $8,880

Income Tax Bracket	Marginal Rates: Elderly	Marginal Rates: Non-Elderly	Difference In Tax Rate on the Elderly
15% Bracket	81.23%	22.51%	+58.72%
28% Bracket	101.33%	35.51%	+65.82%

Medicare Tax Is Regressive
How Medicare Surtax Adds To Marginal Tax Rate
For Different Income Levels

Elderly Individuals

Non-Social Security Income	$22,500	$25,000	$29,000	$30,000
Medicare Surtax	3.09%	5.78%	3.15%	0.00%

Elderly Couples

Non-Social Security Income	$35,000	$37,500	$40,000	$57,500
Medicare Surtax	3.09%	5.78%	3.15%	0.00%

For More Information,
Contact:

National Center for Policy Analysis
7701 N. Stemmons Suite 800
Dallas, Texas 75247

Findings of the National Committee To Preserve Social Security And Medicare:

Medicare Catastrophic Coverage Act: More Out-Of-Pocket Costs, Little Or No Benefits

▪ Number of Senior Taxpayers Underestimated

National Committee estimates, based on income tax returns filed by seniors, show that 14.6 million seniors, almost 47 percent of older Americans, will have a tax liability of more than $150 in 1989 and will, therefore, be required to pay the Medicare tax.

This figure is 24 percent higher than what the government estimated.

By 1993, almost 54 percent of this nation's seniors will pay the Medicare tax.

Iowa Statistics:

The National Committee estimates that 193,763 Iowans, 44 percent of all Iowa seniors, will pay the Medicare tax.

▪ Most Senior Taxpayers Will Be Worse Off

Thirty to 40 percent of Medicare enrollees -- most of the seniors paying the surtax -- will suffer greater out-of-pocket costs for Medicare covered services. This is true even after adjusting for reductions in medigap premiums.

Perhaps most surprisingly, individuals with annual incomes above about $13,000 will lose from this legislation.

Between 9 and 10 million beneficiaries will spend about $100 more a year for health coverage.

Beneficiaries who have employer-provided medigap benefits and who also pay the supplemental premium will have an average premium increase of $333 in 1989 for no increased benefit.

▪ Beneficiaries Will Receive Few New Benefits

Far from being an historic expansion of Medicare, the "new" benefits for all beneficiaries are very limited, consisting primarily of new drug coverage.

Sixty-two percent of all Medicare enrollees and 72 percent of seniors already had medigap coverage. This means that, for a majority of enrollees, most benefits in the catastrophic package were covered by private insurance.

Another 10 percent of Medicare enrollees receive Medicaid assistance and were already protected against these out-of-pocket costs.

An analysis of the Catastrophic Coverage Act benefits reveals that only 24 percent of the benefits were not usually covered through private medigap policies.

For More Information:
National Committee To Preserve
Social Security and Medicare
2000 K Street N.W.
Washington, D.C. 20006

STATEMENT OF REPRESENTATIVE HARRIS W. FAWELL

Mr. **Fawell**. I am pleased to have this opportunity to hear the viewpoints of so many people this morning regarding the Medicare law Congress passed last year. In the 8 months that have passed since the proposal became law, many of the program's beneficiaries have realized that they stand to gain very little from the program, yet will pay much higher premiums and income taxes.

These active citizens have been flooding congressional offices with mail in opposition to the law. I have received over 850 letters from my own constituents outside of Chicago, and over 500 letters from seniors around the country. And these are long handwritten letters detailing how the Medicare law upsets some careful financial retirement planning. By any standard, the amount of mail Members in Congress are receiving on this topic is, at least from my experience, without precedent.

The reasons the seniors give for opposing the law are much the same as mine for having voted against it last year when the final compromise was dropped upon our desks really, a large bill, and a lot of us didn't have the opportunity to fully review it and comprehend all that was in it. But first, the seniors do feel that the income-related premium, or tax, is imposed unfairly. It penalizes those retirees who took pains to make sure they were covered by their employers' pension plans and also had put away money so that they would not be dependent on their Social Security checks solely or upon their children, that they'd have the independence in later years which we all relish. By placing a surtax or a tax up on top of a tax they pay, the very same Congressmen who pledge not to make any changes in the Tax Reform Act in 1986 increase tax rates by up to 28 percent for a large segment of the population before the new tax law changes were even fully implemented. Moreover, anytime in the future when tax rates increase for reason unrelated to Medicare, those seniors who pay income taxes will see their Medicare premiums increase as well.

The other reasons these seniors give for disliking the new Medicare law is that despite the higher costs to them, they still have no protection against the devastating costs of long-term custodial nursing home care which it seems is almost a part of every family in America today, directly or indirectly. Virtually no private insurance is available for long-term custodial care, leaving American families with few options but to spend their savings on this type of care. Congress could have done a great service to its Nation's elderly population in my view by directing its limited resources toward this most catastrophic of health care expenses, and as I have previously indicated, that is here or at least in my district seniors have said this is the top priority. If you're going to mandate us to come up with our own funds then at least subsidize the program for others—which I don't think seniors ought to be obligated to do—then at least they're saying, why don't you give us something that which we believe to be the most catastrophic of all catastrophes that may be facing us.

With this law in place, I believe the Federal Government will have a very hard time trying to devise any new plan to assist seniors with long-term care expenses because of the costs involved and the hostility of seniors to further increases in their Medicare costs. For all of these reasons I, as Congressman Tauke has pointed out, am sponsoring legislation, H.R. 169, to "send Congress basically back to the drawing board." It's kind of hard for us in Congress at times to admit that we can make mistakes; I think we've made a mistake here, but I certainly am going to be interested in regard to what you folks have and how you express your views on this. My bill would simply repeal the law, including the tax surcharge, and establish a non-partisan Presidential Commission on the Medicare Program. Interestingly enough, without a Member of Congress on that Commission, to really look at the health care needs of the Medicare population, determine if we're going to expand Medicare where do we want that expansion to take place. And that includes looking, certainly, at the long-term custodial nursing home care area.

And so I look forward to hearing from all of our invited guests today and their opinions and viewpoints on this new Medicare law. Thank you.

Mr. TAUKE. Thank you very much, Harris.

I have two letters which I ask unanimous consent to enter into the record and let me just read briefly from both. One is from Senator Grassley who says he is sorry that he cannot personally attend the hearing, but would like to, "share my thoughts with you which may be placed in the record if you so please. I share your deep concern about the financial ruin which can befall our Nation's Medicare beneficiaries who face catastrophic illnesses. As you and I both saw at the time last year, the good intentions of the original sponsors of the Catastrophic Health Bill were unfortunately overshadowed by the potentially great costs of the program finally adopted. Given the financing structure of the program, these costs will be shouldered by Medicare beneficiaries themselves, many of whom can ill afford the expense."

Senator Grassley goes on to say, "I am presently reviewing a number of proposed changes in the law and therefore look forward to your committee's findings. For your information I have also requested that the Senate Finance Committee begin hearings to determine what changes should be made to the funding mechanism of the Catastrophic Health Care bill. I wholeheartedly agree with you that the financing arrangements of this program must be reviewed by Congress so that we can be sure we have a program that is fair and can be supported by all of our older constituents."

[Letter from Senator Grassley follows:]

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(319) 232-6657

116 Federal Building
131 E. 4th Street
Davenport, IA 52801
(319) 322-4331

March 2, 1989

The Honorable Tom Tauke
Ranking Republican
Subcommittee on Retirement Income
  and Employment
Select Committee on Aging
U.S. House of Representatives
Washington, D. C.   20515

Dear Congressman Tauke:

I want to applaud your leadership in providing a Congressional forum for open discussion and review of the financing arrangements of the Medicare Catastrophic Loss Prevention Act of 1988 which have so concerned Iowa Medicare beneficiaries. I am sorry that I could not personally attend your hearing, but would like to share my thoughts with you, which may be placed in the record if you so please.

I share your deep concerns about the financial ruin which can befall our nation's Medicare beneficiaries who face catastrophic illnesses. As you and I both saw at the time, however, the good intentions of the original sponsors of the catastrophic health bill were unfortunately overshadowed by the potentially great costs of the program finally adopted. Given the financing structure of the program, these costs will be shouldered by Medicare beneficiaries themselves, many of whom can ill-afford the expense.

At the time the Senate considered its original version of the catastrophic health bill, I stated on the Senate floor my deep concern about the House version of the legislation. I was concerned about the cost of the program, particularly future cost. I noted that if the House-Senate Conference Committee returned a bill like the original House version I would likely vote against the entire package. Although the conference bill was not as bad as the original House version, it certainly was not as good as the Senate's original version.

Committee Assignments:
APPROPRIATIONS
BUDGET
JUDICIARY
SPECIAL COMMITTEE ON AGING

And from the thousands of letters that you and I have received from angry senior citizens, our concerns were obviously well-founded. Indeed, a recent Congressional Budget Office report concluded that over 35 percent of our senior citizens will be required to pay a supplemental premium, which, in some cases, will be substantial.

I am presently reviewing a number of proposed changes, and, therefore, look forward to your committee's findings. For your information, I have also requested that the Senate Finance Committee begin hearings to determine what changes should be made to the funding mechanism of the catastrophic health care bill. I wholeheartedly agree with you that the financing arrangements of this program must be reviewed by Congress so that we can be sure we have a program that is fair and that can be supported by all of our older constituents.

Again, thank you for holding this hearing in Iowa. I look forward to working with you in the future on this pressing problem.

Sincerely,

Chuck

Charles E. Grassley
United States Senator

Mr. **Tauke**. Iowans for Tax Relief also sent testimony, which they wanted included in the record, and again reading briefly from that testimony they say, "We are hearing a growing number of complaints from our members and other Iowa taxpayers about the 15 percent income surtax. Many Iowans are shocked when they discover that each person eligible for Medicare Part A must pay this 15 percent tax on a tax beginning with returns filed in 1990 on 1989 income. We are also hearing many complaints from Iowans who believe it is unfair for the Federal Government to tax half of their Social Security benefits. They plan for retirement in reliance on the promise that Social Security benefits are not subject to the Federal Income Tax. Now that promise has been broken and this is another blow to strain retirement budgets. We believe that many complaints we are already hearing from Iowa taxpayers will become a firestorm of taxpayer anger next year when the new 15 percent surtax will have to be paid by April 15th on 1989 income tax returns. Many retired citizens are not yet aware of this big tax bite awaiting them; when it hits them early in 1990 they will be furious, and their fury will be justified. Many will face real hardship because of this large tax increase. The $800 per person limit on this tax gives little comfort. This is a $1,600 added tax burden on a couple if both husband and wife are eligible for Medicare. Even 800 is a huge expense for many retired people who cannot afford that on limited income. Also $800 or $1,600 per couple is only the beginning. We know that the ceiling of $800 per person will be raised higher in future years."

The taxpayers union goes on to say, "This new tax is especially unfair to many people who were already paying for their own insurance for catastrophic health care. Now the Federal Government has taken away their freedom of choice and forces them to pay for a Federal program which may or may not meet their needs."

With unanimous consent, I will insert both of those letters in the record in total.

[Letter from Iowans for Tax Relief follows:]

IOWANS FOR TAX RELIEF
AND TAX EDUCATION FOUNDATION 800/345-3024
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March 3, 1989

The Honorable Tom Tauke
PO Box 2310
Cedar Rapids, Iowa 52406

Dear Representative Tauke:

I regret that two meetings prevent me from attending your hearing in Cedar Rapids on Monday, March 6. This letter summarizes my testimony for Iowans for Tax Relief.

Iowans for Tax Relief, the nonpartisan taxpayer movement with more than 35,000 members, commends you for your opposition to the 15 percent income surtax on persons eligible for Medicare.

Many of our members are retired citizens, mostly in the middle-income group but ranging from low to high incomes.

We are hearing a growing number of complaints from our members and other Iowa taxpayers about the 15% income surtax. Many Iowans are shocked when they discover that each person eligible for Medicare Part A must pay this 15% tax-on-a-tax, beginning with returns filed in 1990 on 1989 income.

We are also hearing many complaints from Iowans who believe it is unfair for the federal government to tax half of their social security benefits. They planned for retirement in reliance on the promise that social security benefits were not subject to the federal income tax. Now that promise has been broken, and this is another blow to strained retirement budgets.

We believe the many complaints we are already hearing from Iowa taxpayers will become a firestorm of taxpayer anger next year, when the new 15% surtax will have to be paid by April 15 on 1989 income tax returns.

Many retired citizens are not yet aware of this big tax bite awaiting them. When it hits them early in 1990, they will be furious and their fury will be justified. Many will face real hardship because of this large tax increase.

The $800-per-person limit on this tax gives little comfort. This is a $1,600 added tax burden on a couple if both husband and wife are eligible for Medicare. Even $800 is a huge expense which many retired people cannot afford on their limited incomes.

Also, $800 or $1,600 is only the beginning. We know that the ceiling of $800 per person will be raised higher in future years.

The false label of "supplemental medicare premium" is another bad example of deceptive packaging by the federal government. In fact this is a tax -- a heavy, unaffordable tax for many people whose budgets can't stand this new tax bite of up to $800 or $1,600.

Indeed, this 15% surtax is a tax on a tax, which is especially offensive to Iowa taxpayers. We Iowans fought hard in 1987 and won the battle to keep our federal income tax deduction on Iowa income tax returns. We prevented our state government from imposing a state income tax on our federal income tax payments. But now the federal government imposes this new tax on many Iowans' federal income tax payments.

This new tax is especially unfair to many people who were already paying for their own insurance for catastrophic health care. Now the federal government has taken away their freedom of choice and forces them to pay for a federal program which may or may not meet their needs.

This 15% surtax is another bad example of how the federal government breaks its promises. The American people were promised that if they gave up many tax deductions, the so-called "tax reform" law of 1986 would have only two income tax rates: 15% and 28%. This was a lie. The law contained a hidden 33% tax bracket at certain income levels, and an even higher hidden rate hits some taxpayers who own rental property.

Now the federal government has imposed two more and higher tax brackets on persons eligible for Medicare: a 17.25% bracket (15% rate + the 15% surtax) and a 32.2% bracket (28% rate + the 15% surtax). These new brackets will hit especially hard at low-income and middle-income taxpayers.

Whatever happened to the "simple" income tax we were promised?

This unjustified 15% surtax increases the people's distrust and disgust for the federal government and its tax system.

Iowans for Tax Relief urges you to continue your efforts to repeal this unfair surtax. Again we thank you for opposing it.

Sincerely,

David M. Stanley

David M. Stanley
President

Mr. TAUKE. Now we are very pleased to have our first witness, the Deputy Region VII Administrator of the Health Care Financing Administration. Joe, would you please come forward?

The Health Care Financing Administration, for the benefit of our audience, handles the administration of the Medicare and Medicaid programs. And so we're looking forward to the testimony from the Deputy Administrator here in this region.

STATEMENT OF JOE L. TILGHMAN, DEPUTY REGION VII ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH & HUMAN SERVICES

Mr. TILGHMAN. My name is Joe Tilghman; I'm the Deputy Regional Administrator of the Health Care Financing Administration Regional Office in Kansas City. My office is responsible for the federal administration of the Medicare and Medicaid programs in a four-State area that includes Iowa, Kansas, Missouri and Nebraska. I'm pleased to be here today to discuss with you the principal elements of catastrophic health insurance under Medicare.

Catastrophic health insurance represents the most comprehensive expansion of Medicare since the program's inception in 1965. The concept of catastrophic health insurance was forwarded by President Reagan and Secretary Bowen and embraced by Congress over 2 years ago. Following more than a year of congressional debate and months of dialogue between Congress and the administration, the Medicare Catastrophic Coverage Act became law in July of 1988. Its significance lies in the fact that it fills in many of the most pressing gaps in acute care coverage left by the original Medicare legislation.

Catastrophic health insurance protects Medicare beneficiaries from the financial ruin an unusually long or particularly expensive illness may cause. The need to protect Medicare beneficiaries from such risk has become increasingly clear in recent years as the cost of health care has risen dramatically, and with it the burden of beneficiary cost-sharing. While I think most of us are familiar with the details of the catastrophic health insurance benefits, let me outline them briefly for the record.

Under Medicare part A, which is primarily hospital care, the new benefits include several changes in the beneficiary's financial responsibility for inpatient hospital care. Effective January 1, 1989, beneficiaries are entitled to unlimited hospital care following payment of only one hospital deductible per year. In addition, all hospital coinsurances are completely eliminated.

Medicare coverage of skilled nursing facility services is also expanded under this new benefit, with Medicare now paying for 150 days of care annually with significantly reduced coinsurance amounts. In addition, the requirement that a beneficiary must be hospitalized for 3 days prior to being admitted to a skilled nursing facility has been dropped.

To round out part A coverage changes, both the hospice and home health care benefits have been enhanced. Medicare beneficiaries choosing the hospice option are entitled to an unlimited number of hospice days effective January 1 of this year providing a physician certifies that hospice care is appropriate. Those requiring home health care will find the number of covered days for daily nursing care expanded beginning January 1990, which I think Mr. Tauke mentioned earlier. He's responsible for that part of the legislation.

Under catastrophic health insurance, beneficiaries will also be guaranteed that their out-of-pocket cost for physician and other part B Medicare services will not exceed a reasonable amount. In 1990, for example, the cap for such covered part B services is set at $1,370. Medicare will pay 80 percent of the covered part B services until a beneficiary's out-of-pocket expenses exceed $1,370. At that point, Medicare will pay 100 percent of covered part B services. This benefit protects not only those beneficiaries experiencing a sudden catastrophic illness, but will also help with those who have a chronic illness that requires extensive physician services.

The catastrophic health insurance benefit will also provide in-home respite care beginning in January 1991. This benefit allows up to 80 hours of continuous care annually for certain disabled beneficiaries, thus providing needed respite for their usual caretakers. In addition, Medicare beneficiaries will be entitled to preventive screening mammographies beginning in January 1990.

An entirely new benefit, Medicare coverage of outpatient prescription drugs, has also been added under catastrophic health insurance. Beginning in 1990, Medicare will pay for immunosuppressive and certain home intravenous or IV drugs. This benefit will be considerably expanded in 1991 to include all other outpatient prescription drugs approved by the Food and Drug Administration. An annual deductible is required before Medicare payment begins for drug coverage. In fiscal year 1991, for example, the deductible is set at $600. The required coinsurance amounts for drug coverage will be phasing in over the first several years of the program. Fifty percent in 1991, 40 percent in 1992, and 20 percent in 1993.

Finally, catastrophic health insurance provides special protections for low-income beneficiaries. Under the law, States are now required to pay the Medicare premiums, deductibles, and coinsurance of all beneficiaries with incomes below the Federal poverty level. In addition, and I think Mr. Tauke is also responsible for this part of the act, the law allows a spouse who remains at home to keep a minimal level of income and assets when the other spouse is admitted to a nursing home. This provision protects an individual who wants and is able to stay in the community to do so without becoming impoverished by trying to pay the nursing home bills of their spouse.

Clearly, the new catastrophic health insurance benefits have generated much discussion among those concerned about Medicare benefits and their cost. We believe that such discussion is very positive and seek to encourage it. Late last year we mailed information explaining the new provisions to every Medicare beneficiary in the country. We have also established a toll-free hotline number to answer specific beneficiary questions. I'm pleased to note that as of January, over 200,000 beneficiaries have taken advantage of this hotline. In addition, our carriers and fiscal intermediaries have also developed beneficiary outreach programs to handle any specific questions they may receive about catastrophic coverage.

Let me conclude my statement by assuring you that the Health Care Financing Administration is working hard to implement the new catastrophic health insurance benefits and to ensure that the transition to the new benefits, particularly the very complex outpatient prescription drug benefit, is smooth. Implementation of the new benefits is now on schedule, and continues to be on schedule, and we anticipate everything being implemented as provided in the law.

That concludes my prepared my statement and I'm ready to answer questions.

Mr. TAUKE. Thank you very much, Mr. Tilghman. Mr. Fawell, do you have any questions that you'd like to address to him?

Mr. FAWELL. Yes, Mr. Chairman. Mr. Tilghman, I had understood that insofar as the outpatient prescription drug program is concerned, which I gather—as I recall, that will go into effect as of January of 1992, is that correct?

Mr. TILGHMAN. It's phased in over a period of time. Beginning in 1990 I believe it is, part of it will come into effect covering IV drugs and immunosuppressive drugs. Then beginning in 1991 we'll bring in all of the other outpatient drugs.

Mr. FAWELL. '91.

Mr. TILGHMAN. '91.

Mr. FAWELL. All right. I had understood that estimates of HCFA indicate thought that they would estimate that by 1993, as I recall, that there would be a $4 to $5 billion insurance fall in regard to revenues necessary to cover the outpatient prescription drug program. Is that correct?

Mr. TILGHMAN. The HCFA actuaries in looking ahead to 1993 after the drug schedule is fully implemented, does see a small shortfall. I don't know the exact amount of the shortfall, but they do see some shortfall in the revenue sources to pay for the drug benefit.

Because it's so early in the ballgame and this is a totally new concept for us in funding drug coverage, nobody is sure of those numbers. We simply don't have enough information right now, everything is very tentative. As we get more experience, once the thing is implemented fully in 1991, we'll be able to forecast better.

But you're right; there may be some problems in 1993 as far as funding it. We don't know yet how serious it's going to be or if it even will be a problem.

Mr. FAWELL. That's something we in the Congress have been notorious for underestimating an awful lot of expenditures. I think it was in '65 when Medicare first came in. Congress as I recall estimated that the cost by 1990 would be $8 billion, and you and I know it's around $100 billion as of right now, and by 1990 it will be in the area of probably over $100 billion. So a lot of us do not have a whole lot of confidence in these estimates and when we talk about a $31 billion 5-year phase-in program of the Medicare Catastrophic Protection Act, we are a bit concerned about, once the 5-year phase-in program is over, what in the world will the cost of the program be as we commence in the fifth year for instance, with a fully phased in program that could cost us $31.5 billion. And the figures I have from Washington's office is that it would be $4 to $5 billion shortfall on just the prescription drug program by 1993. A lot of us are very concerned that the costs of the program, and therefore the costs primarily to seniors of course, after 1993 are—we have no, absolutely no, handle on what those costs would be.

Do you share—I assume you share our concerns, certainly, with that.

Mr. TILGHMAN. Well, in part. Once you get into a program like this, it's very hard to forecast exactly to the dollar what the costs are going to be. Historically based on 18 years experience working with the Medicare and Medicaid programs, the rate of inflation, the rate of increase in cost seems to outface what people thought it would be in the past.

Mr. FAWELL. The only other point I have is I know you must have done a lot of speaking to various groups since this new law came into effect. The feeling that, at least I have received back in Illinois, is that the emphasis of this program in regard to expansion of Medicare as it affects acute hospital care and physicians care and then the new program of outpatient prescription drugs as being the area where we should pour a great deal of money. Perhaps was not zeroing in in regard to what seniors at least felt was the highest priority of potential catastrophes facing them and that perhaps the money, the $31 billion or whatever it may be, in the first 5 years of experience could have been better used to at least give some kind of partial help toward the meeting of the expenses of long-term custodial nursing home care.

Have you experienced—had that same experience, that seniors have indicated to you that they would have preferred, and I know you're not a Member of Congress so you didn't draft this legislation, but would have preferred that added expenditures to expand Medicare could have more popularly at least been in the area of some kind of aid in the long-term custodial nursing home area?

Mr. TILGHMAN. We have sent a lot of people out from our office over the past 6 months or so to speak to a number of beneficiary groups. The common trend as far as reaction to the Catastrophic Coverage Act doesn't seem to be any concern in particular about the benefits themselves, but more on the financing mechanism. I think a lot of people were unaware of the financing mechanism. Now, as they learn more about it, the fact that it's going to come out of their pocket as opposed to general revenues or some other source, that seems to be the major focus of the reaction we hear from beneficiary groups rather than saying we would prefer the money be spent on this benefit or that benefit.

Mr. FAWELL. The financing, have they expressed also concern about the fact that they're being asked to subsidize others as well as to have a self-financing. It's self-financing but they're also being mandated to subsidize others. Has there been concern expressed about that too?

Mr. TILGHMAN. Right. When it comes to their concern about the financing mechanism, the focus of the concern is primarily on the supplemental premium which is what the more well-to-do beneficiaries are the ones that have to pay that. The ones that are required to pay that are the ones who seem to be expressing the most concern, that they seem to be in their opinion sharing an unfair burden to pay for the financial cost of the new coverage.

Mr. **Fawell**. Well, one of the concerns I—again I'm just reflecting mostly from experience in Western Chicagoland—I know that there's been a lot of emphasis by some who have been defending this legislation that seniors are only concerned about the fact that they're being asked to help finance this expansion of Medicare. It's been my feeling while certainly there is concern about the new tax, because I would agree it is the worst of all modes of self-financing to go into a tax upon a tax and also to ask not only self-financing but subsidizing in addition to that, I also have felt though that at least in my area that seniors are in effect saying, "Look, if expansion of Medicare can only come by means of our financing it or having some part to play because of the debt and deficit problems which are very, very real, then why in the world did you folks in the legislature zero in on an area where by and large—oh, some 70 percent of seniors—have through employer sponsored health programs and/or Medicare, have coverage and of course the very poor have it under Medicaid, why in the world did you foist upon us a new insurance policy so to speak that covers an area where it's already covered by Medicare and we have the ability to find private insurance coverage and totally ignore this growing area of concern to just about every family in America, and that is long-term custodial care?"

So I have found a two-prong complaint. Yes, in regard to they're concerned about the fact that the Congress has sort of forgotten about the promises we made in the Tax Reform Act that we wouldn't raise taxes on seniors and others where we had taken away tax deductions and tax credits, double exemptions, things like that. But I have felt at least in my district that an awful lot of seniors are also saying that if you're going to do something like this, you ought to be zeroing in on that area that—in regard to which we're mostly concerned, long-term or in-home health care. Those areas where we can't go out and buy insurance anyway and Medicare does not cover it.

Mr. **Tilghman**. If I could, I could say a couple of points on that. I'll probably be one of the few people that will defend the Catastrophic Coverage Act today, so I would like to say a couple of things in favor of that.

First, I think it should be recognized that while the Catastrophic Coverage Act that was passed last July does not cover long-term care for Medicare beneficiaries and it's certainly a major concern of all Medicare beneficiaries. It does provide some help for people that are faced with that. And I think as Congressman Tauke mentioned earlier, apparently he was responsible for at least two pieces of the legislation to do that. While it falls short of paying for long-term care, it does provide some assistance and protection. One, by expanding the number and type of home health visits that Medicare will pay for we're providing some assistance to those people who have a spouse in their house that would like to keep their spouse there rather than putting them in a nursing home; it will be easier by being able to get Medicare to pay for expanded home health care which will take effect in January 1990.

Now, a second benefit under the new Catastrophic Act that will help people keep spouses in their home rather than putting them in a nursing home is that Medicare will also for the first time start paying for respite care, up to 80 hours a year for people who qualify. Again these are two things that will help people keep a spouse in their home without having to put them in a nursing home in the first place, which I think is great.

The other thing that it provides is protection against spousal impoverishment which again, I think Mr. Tauke was the author of that particular part of this legislation. And this is today Medicaid, the State Medicaid Assistance Program, is the primary source for paying for nursing home care as far as the public funding goes. Now in order to qualify for Medicaid coverage to pay for a nursing home care for a spouse, it's been necessary for the community spouse, the one who's left at home, to essentially wipe out most of their life savings as well as give up most of their ongoing income in order to qualify for Medicaid for the spouse that has to be put in an institution. Now, under the Catastrophic Coverage Act the community spouse has much greater protection than they've ever had before as far as what it takes to qualify for Medicaid assistance.

So I think two key points are: While the Catastrophic Act does in fact fall short of paying for long-term care, it does take two significant steps in providing additional protection; it makes it easier for a Medicare beneficiary to stay in their own home rather than going to a nursing home by providing additional care that Medicare did not pay for in the past; and then secondly, it provides some financial protection for the spouse to qualify for Medicaid.

Mr. **Fawell**. I'll just—this one observation and then I'll—that's all the questions I have.

The added home health care, of course we have right now, basically you're talking about subacute care after a hospital stay and we all know it's pretty darn difficult to be able to have that kind of care. We're not talking about people coming in to the home, necessarily, to give care. But your sub—somebody has been in the hospital and we know that quicker but sicker syndrome has taken place, so that we're squeezing people out of the hospital much faster and finding, therefore, that people do need types of subacute hospital care in the home and elsewhere, that they have not had before. That does not seem to me that that does a whole lot insofar as custodial nursing home care; really in-home health care. The respite care, I would agree in a very minuscule way limited I believe to people who have been—someone who is living at home with a caregiver in-home and allowing that caregiver to have, I think 70 or 80 hours in total for a year, is certainly a step in the right direction. But a very, very small step in the right direction.

I know Congressman Tauke knows more about the provisions in regard to impoverishment; that's a step in the right direction, too. I guess we have a long ways to go there also. Thank you very much. I appreciate your testimony.

Mr. **Tauke**. Thank you, Mr. Fawell.

Mr. Tilghman, the Health Care Financing Administration is responsible for administering the program. To date have there been any difficulties with the transition to this new program? Are there any problems that have arisen or that we can foresee arising as we attempt to implement the Catastrophic Health Insurance Act?

Mr. **Tilghman**. No, I would say not. That we're all a little bit anxious about the scope of this. As I mentioned earlier, it's the broadest expansion of Medicare benefits since 1965 when it was first enacted. It's going to be an incredible amount of work but at the same time we're also very excited about certain aspects of it, especially the drug benefit. We—right now the Medicare program processes about 350 million claims a year for part B and part A. Under the drug benefit alone that's going to double; we're going to process about 700,000 claims a year for outpatient drugs. While that sounds a little overwhelming, we're a little bit excited about the new concept that's going to be implemented, that was required by the law, that point of sale, place processing system for drugs. So while it's going to be difficult, I think we won't have any problem. Going ahead with the phase-in schedule also helps us out quite a bit; we do not have to do it all by X date, that we've got 3 years essentially to phase in all the new benefits.

Mr. TAUKE. Under the administration of the drug benefit, every—when a senior citizen goes to a drugstore, a pharmacy, and purchases drugs, that pharmacy or drugstore will be tied in to a nationwide computer system that will keep track of that record in order to determine when they've hit the $600 deductible? Is that correct?

Mr. TILGHMAN. Yeah. That's essentially right. We will contract with somewhere between 3 to 5 drug claim processors that will handle a certain geographic area of the country; it will be divided into 3 or 5 areas. Each participating pharmacy—right now we expect somewhere between 90 to 95 percent of all pharmacies in the country to participate in the Medicare program—will have either a personal computer or a terminal that will be connected to a mainframe computer at our headquarters in Baltimore. And when you as a Medicare beneficiary go to the drugstore to purchase the drug called for on your prescription, they'll enter the information—your Social Security number, name and the drug and so on—and then within about 30 seconds they'll get the information back from our main computer in Baltimore saying that you are in fact entitled to Medicare coverage or where you stand in meeting your deductible that year, how much Medicare will pay for the claim. And one of the things we're particularly excited about is that it will also show what other prescription drugs you are currently taking and it will indicate to that pharmacist if there is going to be a problem with any interaction between the five or six drugs that a Medicare beneficiary may be taking. So we're excited about that as being an additional protection that we can offer Medicare beneficiaries.

Mr. TAUKE. I notice that under two of the provisions of the act, the doctor outpatient care and also the prescription drug benefit, that there is a limit on the number of senior citizens who are eligible for benefits under, let's say for example the doctor outpatient care. If more than 7 percent of the eligible beneficiaries apply for benefits in any 1 year, then the deductible that is paid by seniors is increased the following year. Now is it the Health Care Financing Administration that automatically makes that determination as to what the deductible will be the following year?

Mr. TILGHMAN. Right. For the part B deductible which I mentioned earlier—it's not a deductible, the cap of $1,370. The intent of the law is that at least 7 percent of all Medicare beneficiaries would meet or exceed that cap. So we'll have actuaries in our office that will have to propose to, legally we have to send something into Congress saying based on last year's experience, here's what we see the new cap being set at next year. It could be $1,400 or $1600, whatever cap it would take, so that at least—or roughly 7 percent of all Medicare beneficiaries meet or exceed that cap.

The same thing holds true on the deductible for outpatient drugs, only there the percent is 16.8 percent of all Medicare beneficiaries should meet or exceed that cap. So we will have to figure out based on past experience what that cap should be set at in succeeding years, tell Congress that here's what the cap will be this year, and I'm not sure what happens after that.

Mr. TAUKE. But each year we would expect that that cap would be adjusted somewhat?

Mr. TILGHMAN. Exactly.

Mr. TAUKE. Very good.

Well, thank you very much for coming this morning. We appreciate your testimony.

Next panel will consist of a representative of the American Association for Retired Persons, representative of the National Committee to Preserve Social Security and Medicare, the representative of the National Association of Retired Federal Employees and the representative of the Iowa State Council of Senior Citizens.

Has anyone come from the AARP? Apparently we didn't get a representative from the AARP. Okay.

Gentlemen, we thank you very much for your willingness to appear here this morning. Our first witness on this panel will be Allen Johnston, who is the grass roots action Director of the National Committee to Preserve Social Security and Medicare.

Mr. Johnston.

STATEMENT OF ALLEN JOHNSTON, DIRECTOR OF MEMBER RELATIONS AND NATIONAL GRASSROOTS ACTION, THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. JOHNSTON. Thank you, Congressman Tauke. Thank you, Representative Fawell.

It's good to be back in Iowa again, representing the 60,000 dues-paying members of the National Committee that we have here in the great State of Iowa. And Mr. Tauke, it's a particular personal pleasure for me to be back testifying before the Subcommittee on Retirement Income and Employment, a subcommittee for which I was the staff director some years ago, and it was a particular pleasure for me to work with you and your excellent and capable staff in Washington on many issues. And you know we did disagree, I guess, with your staff on some issues, but we had more agreement than not. And one of the things that we now have great agreement with is your stand and your position on the Catastrophic Care Bill.

As our chairman Jim Roosevelt wrote you last summer, Mr. Tauke, to congratulate you and Mr. Fawell for your votes against the Catastrophic Bill, we believe you were right. And we applaud you and your political courage for standing up and voting for your convictions for the bill even though many of the best provisions of the bill are because of your leadership on the Energy and Commerce Committee.

We at the National Committee estimate that there will be 193,763 Iowa seniors who will be paying this new surtax, and we believe that's too many.

Mr. Tauke, I'd like to ask that my statement be inserted for the record and I'll just make some comments and some attachments, if that's all right.

What we have—as I said, the National Committee opposes this bill. And two of the things I would like to insert in the record are a couple of attachments, which are available to the audience. One is this ad which ran in the Washington Post 1 year ago today. And Mr. Fawell, you'll see we caught up with your language, yes. "Congress, we think you should go back to the drawing board". And this was a year ago in March 1988.

And then in May of 1988, last year our Chairman, Jim Roosevelt, wrote an article in USA Today in which he concluded that, "this legislation is no historic first step. It is a historic misstep. It deserves defeat. Seniors have a right to expect Congress to do better, much better."

The third insert for the record is a report just issued last month by our policy staff in Washington. And again as I said, this is the report that documents the fact that there will be many more seniors than originally thought paying the Catastrophic Tax. As I said, there are 193,763 Iowa seniors that we expect to be paying this tax next year; that's 44 percent. And Mr. Fawell, the news is even worse in Illinois, where it's 47 percent and I would bet it's probably higher in your district. Now this research report is based on Internal Revenue Service data. It shows that the people affected by this tax will be 24 percent greater than the numbers Congress was given from the Congressional Budget Office last year. But that's because CBO used Census Bureau data; we used IRS data, and we believe the IRS data is a better place to look when you're looking at who's going to pay what taxes.

I think our member from Burlington, Eva Bruell, described it about as well as anyone when she said this is a discriminatory tax on the elderly who have worked and saved all their lives so as to be a little independent in their old age. And again let's put to rest this notion that it's only the well-to-do seniors, the rich seniors, that will be paying this tax. You know, about a month ago the Chairman of the Ways and Means Committee told the National Press Club in effect that he was tired of having his golf games interrupted by leaving their million-dollar homes on the fairway and to complain about a $10 or a $12 a month tax increase because of Catastrophic. Well, it's not just the rich. And our report shows that seniors with incomes in excess of $13,000 will be net losers because of this particular piece of legislation, and that's not right.

This tax—and one of the things that we hate worst about this tax is the fact that it loads a hundred percent of the cost of these benefits on to elderly. And that breaks a tradition of social insurance principals which have stood fast for 50 years. This is a kid asking only parents like me to pay his property taxes for school programs. And I bet you there are a lot of people out here who are still paying property taxes for schools.

And it's about like asking the farmers to finance farm subsidies or asking the handicapped to pay for making buildings and sidewalks barrier-free or perhaps, Mr. Tauke, even asking Congressmen to pay the tax to increase congressional salaries.

And another thing that's galling is what Mr. Fawell has already alluded to, and that is the fact that in large part this bill duplicates benefits that are already available in the private sector. As Mr. Fawell has said, 70 percent, 72 percent according to our records, already have this in the private sector; they've already paid for it. This will duplicate their coverage. And Medicaid will fill the need for an additional 10 people, so this duplicates coverage that was already there in large extent. And that's too bad.

And one of the signs of the inadequacies in the bill is the things that weren't targeted, as has already been said long-term care, is the fact although the Chairman of the Subcommittee who designed the legislation stated that one—early on—that one of his goals was to eliminate the need for Medigap policies, which we support, the fact is I don't know anybody who has gotten a decrease in their Medigap policy premiums. My parents got a 43 percent increase in their Medigap premium. Now they did not buy it from the National Committee; we do not sell Medigap policies. We survive only on the dues and contributions of our members. But they got it from another organization and they're upset by this double-hit. And of course the fact that there's no long-term care.

So we at the National Committee oppose this legislation on final passage. But although we opposed it, we fought hard to improve the bill and there are many good things in the bill. Many of them added by the Committee on Education and Labor, upon which Mr. Tauke serves. And we've already talked about some of those. And we pushed hard for the prescription drug benefits that are in there, although we think it too is inadequate.

But as responsible advocates we'd like to address a positive plan, and we have laid that positive plan out in an ad which appeared yesterday in the Washington Post and was supposed to appear today in the Cedar Rapids Gazette. If it's not there, it will be in tomorrow's Cedar Rapids Gazette. And it lays out a positive plan for what we see—and again Mr. Fawell, we picked up on your words—"Take this back to the drawing board". "Take it back to the drawing board." And what this plan does—in December we surveyed our members and we found what they wanted and that's what our plan encompasses. It would add a long-term home health care provision, which we think is sorely needed. It would reduce the cost that seniors pay from 100 percent to 25 percent. And it would add cost controls, something that doesn't happen in the current legislation. And that's a positive plan that we have put forward.

And although we find the supplemental premium, the so-called supplemental premium, to be very odious, we find it even more unacceptable that 100 percent of the costs are loaded on seniors. But we are not fighting just a proposal now; it's the law. And the law says that seniors will pay the highest tax rates, as Mr. Tauke has said, of any Americans. And one thing about—if this was targeted to the well-off, one thing that—it doesn't make any sense because of the cap on the amount of the premium. A cap such that it has the effect that someone with an income of $500,000 can pay exactly the same tax as a person with $50,000, and that does not make any sense if you're arguing this was a bill that takes the money away from the wealthy.

But it is the law, and the Members of Congress who sit on the Committee of Ways and Means which wrote much of this bill have been bought in telling our Washington lobbyists that they will not even discuss repealing the senior surtax. And although it may make us feel good to get mad, we believe we'll feel better and we'll feel better for longer if we get even. And we believe that the best way to get even is to fix this Catastrophic Care Bill. And that's why Jim Roosevelt has authorized a mailing to all of our members, to 3 million of our members, myself and the other 3 million other members, calling on them to write to Members of Congress to fix this particular piece of legislation. Because our membership survey shows that we are willing to pay, seniors are willing to pay their fair share for benefits they really, truly need. And I know I'm willing to dig a little deeper on a personal level to pay for home health care, because I know at least one senior who can use that. And that's my dad. And I also know that until the prescription drug coverage phases in in the 1990's, all that he is going to get and my mother is going to get from this is a 25 percent increase in his income taxes and a 43 percent increase in his private Medigap policy. And as the son of two Notch victims, that adds insult to injury, insult and injury to insult and injury.

So, Congressman Tauke, Congressman Fawell, I pledge to you and to the Iowans assembled here that the National Committee will work with you and other enlightened Members of Congress to take the Catastrophic Act back to the drawing board.

[The prepared statement and attachments submitted by Mr. Johnston follows:]

**NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE**

2000 K Street, N.W., Suite 800, Washington, D.C. 20006 (202) 822-9459

STATEMENT OF

ALLEN JOHNSTON
DIRECTOR OF MEMBER RELATIONS AND
NATIONAL GRASSROOTS ACTION
OF
THE NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

SUBMITTED TO
SELECT COMMITTEE ON AGING
SUBCOMMITTEE ON RETIREMENT INCOME AND
EMPLOYMENT
U.S. HOUSE OF REPRESENTATIVES

REGARDING
THE MEDICARE CATASTROPHIC COVERAGE ACT

MARCH 6, 1989

Thank you for holding this hearing, Congressman Tauke.
I am Allen Johnston, Director of Member Relations and National Grassroots Action at the National Committee to Preserve Social Security and Medicare. I have returned to Iowa today to represent the organization's five million members and supporters including 60,000 members here in Iowa. More than seventy-five percent of our members are sixty-five and over and directly affected by the Medicare Catastrophic Coverage Act.

When this bill was debated on Capitol Hill, the conventional wisdom was that the legislation was good for seniors. Mr. Tauke, you were one of the few who look the time to analyze the legislation. You were right to vote against it and we applaud your political courage for doing so.

Seniors realize that the legislation does not cover the real catastrophic expense of long-term care as advertised. Seniors agree that placing 100% of the cost on seniors is unfair. New facts show the discriminatory catastrophic surtax means that thirty to forty percent of seniors will be worse off than before the legislation was passed. The National Committee estimates that 193,763 Iowan seniors will be paying the new surtax.

Our National membership survey shows that less than five percent of seniors support the Catastrophic Care bill. We have received thousands of letters from National Committee members angry over this legislation. And similar letters are pouring into offices on Capitol Hill daily. Over three quarters of a million of those letters will be in response to a Legislative Alert sent by Chairman James Roosevelt to National Committee members.

The next step is harder. That step is converting senior outrage into a politically realistic solution. This hearing is part of that process and we appreciate your invitation to participate. Our members have said that they want two things: expanded coverage for long-term care and new financing.

Today's Cedar Rapids Gazette carries an ad – almost identical to one in Sunday's Washington Post – that clearly states where the National Committee stands on the need to fix the Catastrophic Coverage Act.

Our message to Congress is "Go Back to the Drawing Board" to:

- **add long-term home health care**
- **reduce the cost to seniors so they pay no more than 25% of the cost and**
- **add revenues from the general population by extending the Medicare payroll tax on all the earnings of the top five percent of wage earners.**

We are not newcomers to this stand. I have also brought with me copies of an ad we ran one year ago in the Washington Post warning Congress that "seniors won't thank you," and last May 10, Chairman James Roosevelt wrote an article in U.S.A. Today opposing enactment of this legislation. Mr. Chairman, we hope these ads as well as our research report on the Catastrophic Coverage Act can be made part of the Record.

PAYING MORE FOR LESS

Let's get away from the notion that the surtax only affects well-off seniors. Our research, based on Internal Revenue Service data, shows that almost half of all older Americans, or 14.6 million seniors, will pay a Medicare supplemental tax in 1989. This is 24 percent higher than the Congressional Budget Office estimated using Census Bureau data. Census income information is based on what people voluntarily tell door-to-door census-takers and may often be underreported.

Some legislators and senior groups believe that the more educated seniors become about the Medicare Catastrophic Coverage Act, the more they will like it. They are wrong! The more seniors realize how little they are getting for the amount they are going to pay, the angrier they get. Clarice Gilliam of Amarillo, Texas, wrote, "After studying all the material I have received [about the] Medicare Catastrophic Coverage Act, I'm convinced the cost is going to be more for senior citizens than the benefits received..."

This member is correct. Most senior taxpayers will be worse off. To quote directly from a Congressional Budget Office analysis, the net result of the fully implemented Medicare Catastrophic Coverage Act will "reduce out-of-pocket costs for the poor and near-poor enrollees, while increasing costs for other groups." The National Committee estimates, based on CBO's data, that individuals with annual incomes above approximately $13,000 will lose from this legislation. Between nine and ten million beneficiaries will spend about $100 more a year for their health care needs.

What angers seniors most is that they feel penalized just because they have been saving and investing during their working years. As one Iowa member, Eva Bruhl from Burlington, described it, "This is a discriminatory tax on elderly people who have worked and saved all their lives so as to be a little independent in old age." Virginia Sutton of Springfield, Illinois, says, "it penalizes one group [which] through thrift, hard work and living within their means have tried to provide for themselves a decent living in their retirement years. Seniors have about all they can handle now. Once they take from their savings, there is no way to replace it." Ivenella and John Carlsen of Carmichael, California, write, "We have worked all our adulthood to raise and educate our children, buy a home, and put away the little amount we could for our senior years...and now the government has a plan to dip into our savings with catastrophic tax."

The "seniors only" tax does not make sense. That is akin to asking parents to pay school taxes; farmers to finance farm subsidies; or asking the handicapped to pay for making buildings and sidewalks barrier free. This type of "user fee" mentality turns up-side down the concept of social insurance upon which the Social Security and Medicare systems were built.

A large number of middle income seniors are paying more for benefits most of them already had through medigap insurance. And despite the $30 billion in taxes and premiums over five years, seniors don't have long-term care. Seniors want to remain independent in their old age. The fear of needing long-term care - or worse, the reality of needing it - is the problem we must alleviate. One member from Murphy, North Carolina, writes, "Since my wife and I are in our seventies, you will understand that the astronomical cost of long-term care is for those of us of only modest means, of great concern. This expense would wipe out completely the savings which we accumulated in a life-time. And the survivor would be reduced to the status of a pauper. I think, we deserve better than that."

Another example of the desperate need for long-term care is the 76-year-old Michael DeLois from Hopedale, Massachusetts, who is caring for his 69-year-year old wife, a stroke victim, "The stroke blew a hole in her brain the size of a quarter, but after six months in a nursing home I had her brought home. I gave up my salesman job just to care and watch over her; now I have been caring for her for 12 years. I had Medicare, but that wasn't enough and I spent all my life's savings to do all I could to help her recover.... I need help to care for her. We live on a Social Security pension."

A SOLUTION

Clearly, the flaws in this law must be addressed. Most lawmakers who voted for the bill acted in good faith believing they were doing seniors a great favor. Now a growing number of lawmakers realize that seniors are angry and feel betrayed by their representatives in Washington. Most legislation that has been introduced in Congress (more than a dozen bills) would repeal, make voluntary, or postpone the law. Although we opposed enactment of this legislation, the National Committee believes, as it always has, that the best solution is to fix the problems in the bill.

In our December 1988 survey, National Committee members wanted to add long-term care and change the financing. They did not want to repeal the law. Those with incomes of $15,000 or more felt they could afford to pay for approximately 25% of the cost.

The National Committee has developed a plan that achieves those goals. It would fix the catastrophic law by building on the original goals of providing affordable coverage for catastrophic health care expenses and take a first step in providing catastrophic long-term care protection. Even with more benefits, the costs to seniors would be cut in half, just by dropping the unneeded limit on out-of-pocket doctor fees and by extending the Medicare tax to all earnings above $48,000.

We propose to keep the long-term hospital stays and all other new Part A benefits -- most of which are already in place -- the prescription drug benefit, protection from spousal impoverishment, and the provision which requires Medicaid to pay out-of-pocket Medicare costs for seniors with incomes up to 100 percent of poverty.

The National Committee plan calls for eliminating the expensive $1,370 cap on doctor's bills and prohibiting doctors from charging more than

Medicare approves would help more seniors and still reduce the cost. The cap is so high that only seven percent of Medicare enrollees will benefit in any one year and only after having run up $6,850 in doctors bills, not including what some doctors charge above what Medicare allows. Seventy-two percent of seniors have private health insurance policies that pay most copayments already. Another 10% are protected from these charges through Medicaid. However, very few people have protection from extra charges by physicians. The catastrophic legislation does not provide that protection and neither does the average medigap policy.

We propose adding long-term home health care for disabled seniors and children. Long-term home health care would be a first step towards comprehensive long-term care coverage. Since not even Medicaid covers much long-term home health care, this plan would fill a significant benefit gap. Ill seniors prefer to be cared for in their own homes, and if more home care was available, the dreaded move to a nursing home could be prevented or postponed.

How do we propose to pay for this? First, by requiring all earnings to be subject to the Medicare payroll tax. This means that wages over $48,000 annually would be subject to the Medicare tax of 1.45% -- which affects only five percent of employees and self employed. And second, by requiring all state and local employees to pay Medicare payroll tax. Most of these people benefit from Medicare in retirement anyway through a Medicare-eligible spouse -- without contributing like other workers.

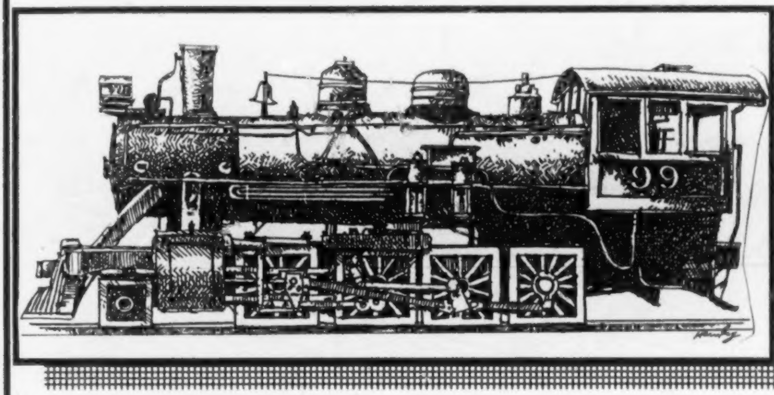
What would seniors have to pay? Even with the addition of long-term home health care, seniors would be contributing about 25% of the cost of the new proposal, rather than 100% as in the original legislation. They would have to pay only half of what the catastrophic law currently requires -- half the monthly premium and half the supplemental tax.

But the facts are that the law now says that seniors will pay a surtax of 15 to 28 percent in the next few years and the Members of Congress who sit on the committees which write the laws have been blunt in telling our Washington lobbyists that they will not even discuss repealing the senior surtax. We believe seniors would be willing to pay their fair share for benefits they truly want and need. That does not happen under the current law and we want to fix it. But if it cannot be fixed, we want it repealed.

CONCLUSION

Far from providing an historic expansion of Medicare, only one-fourth of the overall cost of the legislation will buy new protection for seniors that they did not already have through private insurance or medicaid. Seniors are being asked to pay more for benefits they did not ask for and do not need. The National Committee urges [illegible] to fix the catastrophic act by adding a long-term home health care benefit and by replacing part of the senior financing with broad-based financing.

Take 'Catastrophic Care' Back To The Drawing Board



There's too much right about the Catastrophic Coverage Act to repeal the law. But there are too many flaws in the design to leave it the way it is.

Our 60,000 Iowa members want the law fixed. As we have said for almost two years, that means a broad-based financing approach. And it means including some form of long-term care.

The National Committee has a plan to accomplish these goals while reducing senior citizens share of the cost, without adding to the deficit. It hinges on applying the 1.45% Medicare payroll tax to earnings over $48,000. A Harris poll conducted last year found strong approval for this approach--even among the five percent of wage earners who take home more than $48,000 annually.

The National Committee plan would:

- provide home health care to both seniors and children;
- cut seniors' share of financing from 100% to 25%;
- provide seniors with health care cost control;
- drop one of the costliest but least needed provisions;
- add not a penny to the Federal deficit.

Over the next few weeks an estimated 750,000 letters from our members will arrive on Capitol Hill asking the Congress to listen...and to put the law on track.

National Committee To Preserve Social Security and Medicare
2000 K Street, N.W., Suite 800, Washington, D.C. 20006

Published in Cedars Rapids Gazette, 3/5/89

The Washington Post 1/31/88

Seniors Won't Thank You.

A vote for the so-called "catastrophic" care legislation now pending is a vote you'll regret this November. For limited improvements in health care coverage under Medicare, premiums will jump for nearly every senior citizen. We support effective, fair catastrophic protection. But the pending legislation remains silent on cost-control, ignores the real problem of long-term care, and loads the entire cost of new coverage on already hard-hit senior citizens.

> *"As drafted, the legislation represents a reckless insistence that the last quarter century has nothing to teach: It is likely to spark a surge of spending on high-ticket, high-tech medicine, setting us back years in our cost-containment efforts. It will surely cost far more than Congress estimates, maybe twice as much."*
>
> *—Joseph A. Califano Jr., former Secretary of the Department of Health, Education and Welfare*
> *New York Times Magazine, March 20, 1988*

Political leaders who think that seniors will thank them for this flawed and expensive piece of legislation are deluding themselves. Those who believe that passing this bill would be a good "first step" toward true catastrophic care relief are mistaken. Passage of H.R. 2470 would be a step in the wrong direction toward 100% financing of other Medicare programs by the elderly.

Don't make a mistake that will harm and anger your senior constituents. Vote against the pending catastrophic care legislation.

Go Back to the Drawing Board.

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE
JAMES ROOSEVELT, CHAIRMAN
2000 K ST. N.W. WASHINGTON, DC 20006

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"USA TODAY hopes to serve as a forum for better understanding and unity to help make the USA truly one nation."
—Allen H. Neuharth
Chairman and Founder
Sept. 15, 1982

John C. Quinn
Editor

John Seigenthaler
Editorial Director

OPINION

The Debate: CATASTROPHIC CARE

Today's debate includes our opinion that Congress must act now to provide catastrophic health care coverage and begin work on long-term care, opposing views from Texas and the District of Columbia, other views from California and Georgia, and voices from across the USA.

JAMES ROOSEVELT

An opposing view

This health plan is a serious misstep

WASHINGTON — "Catastrophic health care coverage" — the best part of this legislation is the title.

In truth, the pending bills ignore the real catastrophic care issue — long-term illnesses, the soaring costs of which can destroy any family's economic security. And they boost Medicare premiums and impose a new "seniors only" tax on those with even modest incomes.

Catastrophic care should mean care at home or in a nursing home over a long period of time while one struggles with a chronic disease or recuperates from a serious illness or accident. One in five seniors will need this kind of care. Yet, this legislation doesn't provide any Medicare help for nursing-home patients or their families — despite the fact nursing-home care costs Americans an average of $25,000 a year and despite the fact there is little good, affordable, private insurance available.

But these bills focus on prescription-drug coverage and acute care in hospitals. Of course, that's needed — but not at this cost. This legislation virtually guarantees disastrous future Medicare premium hikes because it ignores the one lesson that Medicare has taught us every year for the past 20 years — medical costs are out of control.

Even though seniors still are reeling from January's 38.5% premium hike and even though statements by Health and Human Services Secretary Otis Bowen indicate enactment would more than double the current $24.80 monthly premium by 1992, these bills ignore the pernicious problem of runaway costs. That fact led former HEW Secretary Joseph Califano to conclude: "It represents a reckless insistence that the last 20 years have nothing to teach us."

That should be reason enough to doom a bill. But this one has even greater faults.

Its biggest flaw is abandonment of the "social insurance" concept upon which most of our nation's great programs have been founded. Instead of spreading the costs across the entire population to minimize the individual load, this bill employs the "user fee" concept to dump the entire cost on already overburdened seniors — a philosophy akin to imposing school taxes only on parents.

The legislation doesn't stop with just a flat premium hike; it also imposes a "supplemental premium" — in reality, a special tax only on seniors, and not just wealthy seniors. Even those with modest incomes will get a substantial additional tax bill from the IRS.

Under the House version, a senior with $10,000 adjusted gross income, for example, would be slapped with a supplemental tax of $360 — on top of the already escalating Medicare premium. Given the current lack of cost control, that would jump to $508 by 1993.

This bill is no historic first step. It's a historic misstep. It deserves defeat. Seniors have a right to expect Congress to do better — much better.

James Roosevelt is chairman of the National Committee to Preserve Social Security and Medicare.

**NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE**

2000 K Street, N.W., Suite 800, Washington, D.C. 20006 (202) 822-9459

FLAWED CATASTROPHIC HEALTH COVERAGE

The National Committee believes that the financing of the catastrophic health coverage law is flawed because it substitutes social insurance financing with senior only financing. For the first time since the beginning of Medicare in 1965 enrollees will be required to pay for the entire package of new benefits. Once seniors realize how much they will be required to pay in Medicare premiums and the limited nature of the expanded coverage, they will be angry and upset.

- January 1989, the monthly Part B premium, paid by all beneficiaries, will go up from $24.80 to almost $32 – almost twice the 1987 premium of $17.90.

- Senior citizens will pay higher income tax rates than other Americans. The full impact of the cost of catastrophic coverage on seniors may not be realized until seniors fill out or estimate their income tax returns for 1989. More than 10 million seniors will have to pay a special "supplemental premium" equal to 15% of their federal tax liability up to a maximum of $800 for individuals and $1,600 for couples. The supplemental premium increases to 28% of tax liability and a maximum of $1,050 for individuals and $2,100 for couples by 1991.

- Despite the cost to seniors, Medicare will still not cover the true catastrophic cost of long-term illness. Seniors will still be impoverished when they must enter a nursing home at an average cost of $25,000 a year or get daily home care at about $18,000 annually. The new coverage is limited primarily to hospital, doctor and drug coverage.

- The nearly 70% of seniors who purchase private medigap insurance may be surprised to find that the new law may not lower the cost of private supplemental Medigap insurance. Primarily this is because the catastrophic law does nothing to restrain increases in physician fees.

- The new law does contain some good provisions strongly advocated by the National Committee: prescription drug coverage, prevention of spousal impoverishment, respite care, and preventive mammography screenings.

Issue Brief
Policy and Research Dept., September 1988

Mr. TAUKE. Our second witness on this panel is Mr. Cliff Humphrey, who is the First Vice-President of the Iowa State Council of Senior Citizens. Mr. Humphrey, if one of your colleagues there could put a microphone over in your direction—

Thank you very much for your appearance here, Mr. Humphrey.

STATEMENT OF CLIFF HUMPHREY, VICE-PRESIDENT, IOWA STATE COUNCIL OF SENIOR CITIZENS

Mr. HUMPHREY. Thank you, Congressman. I am Cliff Humphrey, and I am the vice-president of the Iowa State Council of Senior Citizens. We are an affiliate of the National Council of Senior Citizens, which was a leading player in the fight to enact Medicare 25 years ago.

We appreciate the opportunity to present testimony on this very important issue. It is one we have heard a lot of comment and concern about.

First of all, we applaud the additional benefits which the Catastrophic Protection Act provides as a step in the right direction. Senior citizens and those who work closely with them have long known that Medicare, although an essential program, has some major gaps. This legislation begins to close some of these gaps.

We are especially pleased to see for the first time, the inclusion of outpatient prescription drugs. We have worked closely with many seniors for whom prescription drugs are a major expense. It is a step in the right direction to recognize prescription drugs as the major health care expense which they are.

We don't agree with those who say that few seniors will benefit from this legislation. Approximately 22 percent of Medicare recipients will collect benefits from the act when all phases are implemented. We feel it is important to stress the insurance aspect of Medicare. Catastrophic coverage, by definition, is designed to help the relatively small number of individuals who will experience catastrophic medical expenses. The basic concept of insurance is to spread the risk over a large group, making it affordable for everyone. Catastrophic protection is like other insurance; most people hope they will never have to benefit from their auto or fire insurance policies.

Many persons are concerned that this legislation does not cover long-term care, which is often seen as the biggest need affecting seniors. There are steps, admittedly small, in the act which expand long-term care coverage. The act provides increased respite care, home health aide care, and, perhaps most importantly, provides for a decent standard of living for spouses of institutionalized seniors. This spousal impoverishment provision will ease the worries of many seniors.

We strongly support a comprehensive long-term care bill while recognizing that it is a very complicated and expensive proposition which will require some time to develop and implement. We have lobbied for long-term care legislation in the past and will do so until this very important need is met.

Our biggest concern with the Catastrophic Act is the way it is financed. We believe the financing is flawed and unfair. We do not object to progressive means of financing these benefits, under which wealthy individuals are required to pay more than the poor. Nor do we object to the financing mechanism which provides a subsidy to the lower income persons. But we do object to the basic principles underlying the mechanism which was chosen to finance the benefits; namely, that the benefits would have to be paid for entirely by the elderly.

This principle was incorporated into the new law, because President Reagan insisted at the outset that any new Medicare benefits would have to be paid for by the seniors themselves. And many Members of Congress went along with this principle because as a result of the huge Federal budget deficit that have been run up under the Reagan administration, there simply wasn't any money in the Federal treasury to pay for new benefits.

Requiring the elderly to pay for the entire cost of the catastrophic benefits is wrong for several reasons. Most importantly, it violates the basic social insurance principles which have formed the basis of Social Security an Medicare. This could establish a dangerous precedent for undermining these programs in the future. Furthermore, the net result is that middle and upper income seniors have to shoulder the entire burden of paying for the subsidizing for the lower-income elderly. This burden should properly be shared by all of society, not just the more fortunate segment of the elderly.

We do not support repeal of this legislation. Given that the legislation includes an important expansion of benefits, we do not, so to speak, want to throw the baby out with the bath water. We do strongly urge Congress to find other ways of funding the Catastrophic Act, thus removing the additional financial burden from the backs of the elderly. This should be done by substituting other revenues based more directly on traditional social security financing principles.

Again, I thank you for the opportunity of testifying today.

Mr. TAUKE. Thank you very much, Mr. Humphrey. Our next witness is Lonnie Conger, who is the President of the State of Iowa Chapter of the National Association for Retired Federal Employees. Mr. Conger.

STATEMENT OF LONNIE CONGER, PRESIDENT, STATE OF IOWA CHAPTER OF THE NATIONAL ASSOCIATION FOR RETIRED FEDERAL EMPLOYEES

Mr. CONGER. Thank you, Congressman Tauke and Congressman Fawell.

For all of you fellow Iowans that are here today, I'd like to say at the outset that we met in National Convention in Little Rock, Arkansas last September and the National Association at that time, in the convention mandated the national officers, the paid officers who are in Washington, D.C., the resident officers there, to study this Catastrophic Bill and what it had to say to us as Federal employees. I represent some 17,000 Federal retirees in the State of Iowa and perhaps in a sense a million and a half Federal retirees across the country.

In a recent communication from the national office, these are the facts that they present now as to where it places us as Federal retirees. There are more than 28 million people eligible for part A of

Medicare. Of that number it is estimated that 45 percent will be liable for the new part A Medicare surtax. Among the Federal retirees who are enrolled in the Federal Employees Health Benefits Program, 699,926 have both Medicare Parts A and B; 58,587 have Part A only; 68,245 are enrolled only in Part B; and 174,346 Federal employees have no Medicare coverage at all. These are the figures as of March 1988.

In 1989 the maximum Medicare surtax of $800 will be paid by Part A Medicare eligible individuals whose Federal Income Tax liability is at least $5,400. This roughly equals a taxable income of about $27,573. I might interject at this point that my tax man, when he did my taxes told me that next year it would be approximately $225 for myself and $225 for my wife as starters, and this will progress in the days ahead.

Married couples who are both Medicare eligible whose tax liability is at least $10,800 which roughly equals taxable income of $52,384 will pay the maximum Medicare surtax of $1,600 or $800 each in 1989.

In 1989 and the following years, the Medicare Catastrophic Surtax will be calculated as follows: In 1989, 15 percent or $22.50 for each $150 of Federal tax liability; in 1990, 25 percent or $37.50 for each $150 in Federal tax liability; in 1991, 26 percent or $39 for each $150 in Federal tax liability; in 1992, 27 percent or $40.50 for each $150 in Federal tax liability; 1993, 28 percent or $42 for each $150 in Federal tax liability.

This Medicare surtax which begins at 15 percent and rises to 28 percent by 1993 gives the elderly the highest income tax rates in the country. Those who pay the surtax will in effect pay Federal Income Taxes at the rates of 17.2 and 32 percent rather than the current rates of 15 and 28 percent.

The maximum medical surtax which is $800 for individuals in 1989 rises $50 per year, to $950 in 1992 to $1,050 for individuals in 1993. This amount is doubled for Medicare eligible couples.

The surtax penalizes the very people who may have sacrificed and saved for their retirement years by taxing income from savings and investments which may deprive them of income needed for support.

The new Medicare catastrophic benefits are designed so that a constant share of beneficiaries would be eligible for benefits from a catastrophic limit each year. The Public Law 100-360 dictates that only 7 percent of the average number of enrollees during the year may become entitled to the benefits from the Catastrophic Part B coverage. The law further states that only 16.8 percent of the average number of enrollees during a year will be able to benefit from the prescription drug coverage. In addition, only 7 to 16.8 percent of the Part B beneficiaries will be able to qualify for the respite care provisions due to having to meet either the Part B catastrophic limit or the prescription drug deductible. Long-term and custodial nursing home care is not covered under this legislation, despite the fact that it is by far the largest out-of-pocket expense most elderly face, and can average $25,000 per person per year. These elderly who do spend more than $2,000 a year in out-of-pocket medical expenses or expenses not covered by insurance spend 81 percent of that money on long-term care. In 1984, Medicare covered only 2.1 of the nursing home costs of the Nation's aged.

It is widely speculated for the most Medicare eligible individuals, this expansion of Medicare will provide less protection for more money than comparable benefits currently available to them. According to the Health Insurance Association of America, one-third of the Nation's elderly currently have catastrophic coverage as a fully paid benefit from the retirement plan and will gain nothing from the additional surtax and premiums they pay. Approximately 70 percent of the nation's elderly are already covered by private insurance policies against these expenses. Only 20 percent of the Medicare population has no other supplementary health insurance coverage.

And after 1993, the law permits the tax to be increased by 1 percent per year for $150—or $1.50 for $150 of Federal Income Tax. To fund the catastrophic benefits, if that adjustment still falls short, the Part B premium is then increased to shoulder the rest of the cost. This is of significant consideration when you note that many believe the surtax receipts will not be able to keep pace with the increasing cost.

I'm might further add that we believe that the Congress had concern for the elderly when they brought this act into being, but many of our people are saying it is truly a catastrophe. Catastrophic it's called, but it's truly a catastrophe.

And in conclusion I'd like to say that we would believe that if—or ask the question, why not have a separate new Catastrophic benefit into the optional Medicare program and call it Part C? Give an option to this program. Surely if the levels of cost and coverage are as market competitive as proponents maintain, there will be no shortage of takers to provide the financing.

Thank you, Congressman Tauke.

Mr. TAUKE. Well, I want to thank all of you for your testimony and for your suggestions. Now if you'll allow us to ask some questions. Mr. Fawell?

Mr. FAWELL. Thank you. Let me—this is strictly a view coming from a frustrated Congressman because we don't have money and I—as a bit of the context to the question and I guess the circumstances which face us in Congress in general, I would say this: That, you know, first of all we have this debt and this deficit problem. To my way of thinking it—I have been in Congress only for 4 years and to my calculations we've added $1 trillion to the national debt. Approximately a quarter of a trillion per year. That includes borrowing roughly about $100 billion per year from our trust funds, including Social Security, to the tune of I think about $41 billion during this current year. With no ability of which I have any knowledge of being able to pay those trust funds back, especially Social Security. So we've, Congress has been—I'm just again stating my opinion here—we have been spending in a promulgate way for a long time and we have taxed and we have spent and then we have gone into borrowing and spending. And both of those options now are fading away; even, I think the biggest spenders in Congress are recognizing that you just cannot continue to borrow and pass on to subsequent generations the obligation to repay. And so borrowing and spending is out of vogue. Or not completely, I think some would go forever on that. But the other way to raise revenue would be to print money very fast, and I trust we're not doing that.

The final way of raising of money is to simply mandate a social obligation upon some particular group of people. And that's what in vogue now. And what we have here is a good example of that. What heretofore has not been the obligation of the recipients, we're now moving toward mandating—we have, in fact, in this bill mandated—we have a lot of other bills where for instance insofar as the entire problem of delivery of health care services is to be solved by just mandating. For instance, small business people of America, you just have the responsibility for the 37 million that allegedly do not have health care coverage will just give it to you. And if you go out of business, go bankrupt, cannot produce the 19 million jobs that you did in the last 6 years and the great American revolution that puts Europe to shame insofar as expansion of business is concerned, that's your problem.

What I'm getting at is that from my view we have three basic areas where we can expand Medicare, and it's going to take money from somewhere. And the first is the hospital physician traditional acute medical services covered by Medicare; we've added prescription drugs to that now. The second would be in-home health care; also a very costly area. And then third, long-term custodial nursing home care.

Now, if one were to take my assumption that I don't where we would get the money to cover expansion in all three of these categories, but if we were to, if we had some funds that we could use, which, for each one of you, which of these three categories would you believe to be of the highest priority in terms of the expansion of Medicare? Would it be expand the basic coverage under hospital and physician acute traditional services, which Medicare has always covered, with the addition of prescription drugs, number one. Or would it be to expand in the in-home health care area, or would it be in the long-term custodial nursing home care category? If each one of you would care to respond to that, I would appreciate it. Because I want to know what is the highest priority, as you see it, for an expansion of Medicare.

I agree with all of you that we went in the wrong direction with the Catastrophic Bill.

Mr. Conger, would you like to start off?

Mr. Conger. When I retired from Civil Service, I sold real estate for a little while. And one of the things, one of the—an elderly couple, I sold their home and from the receipts, the net receipts that they received, they went into a nursing home, nursing home care. And that—their total receipts were gone in a year and a half, their total receipts were gone in a year and a half. And it would seem to me that as we look at this thing and in visiting the various chapters across our State, and last year I traveled, my wife and I traveled over 10,000 miles across visiting with various people within our State. And again and again, it's the long-term nursing home care that I get the feedback on. So I would suppose that that's where I would take that aspect, long-term nursing home care.

Mr. Fawell. Thank you. Mr. Humphrey?

Mr. **Humphrey**. I will agree with Mr. Conger to that respect, too. We have seen, in our State and probably all over the United States, where the couple have been taken completely out of the picture as far as finances are concerned to take care of one person in the nursing home. And to me, in-home health care is so much cheaper than nursing home care is that I do not see why we cannot have more in-home care, because the fact that the Government saves money on that, unless expense in the nursing home. Because nursing home is the last ditch. And with in-home health care you may prevent that last ditch care.

Mr. **Fawell**. I'm not—between—I would agree with you certainly, in-home health care is very important and if one can obtain the proper in-home health care, you can at least forestall, as we did with my mother-in-law for instance who is now in a nursing home, that day when custodial care full-time is needed.

But my hypothetical would be, well, assuming that we could not say that every man, woman and child in America that may need in-home health care is something that we can afford or let's say—well, I still want to know what would be your druthers. If we could only afford one of these three, would you opt though for the long-term custodial nursing home care as being where we ought to expand or would you opt to say no, it would be for the in-home health care?

Mr. **Humphrey**. I'd say in-home health care.

Mr. **Fawell**. All right.

Mr. **Humphrey**. Because, like I said before, I think I said it, maybe I didn't come across clear. But if you take care in the home, people are more satisfied in the home even if they're sick, it would prolong that going into the nursing home and when they did come to the nursing home it would be a shorter time, that's where we're coming from.

Mr. **Fawell**. All right, thank you.

Mr. Johnston.

Mr. **Johnston**. Mr. Fawell, I will agree with Mr. Humphrey. That I think in-home care would be the first priority, and I will even tell you how I would suggest paying for it.

It's a suggestion that we made a year ago or more than a year ago to the Senate Finance Committee, after the House had passed this piece of legislation with 100 percent senior financing with the benefits they had. We tried to lobby the members of the Senate Finance Committee and tell them to get rid of the financing and replace it with an extension of the Medicare payroll tax on workers who earn more than $48,000 a year. You know, there's two tax rates, Social Security and Medicare. Seven and a half percent of the first $48,000 you make, and zero of every dollar you make in excess of $48,000. And I know everybody out there has that kind of income, and if you, you're one of the top 5 percent of the workers in the country. That would be enough to pick up about $6 or $7 billion a year which could be used to replace it and affect only the top 5 percent of workers.

Now, we tried to convince the Senate of that approach after the House has made the mistake; they didn't buy it but they did include that same tax rate increase in their bill, but would have allocated that money toward deficit reduction. And we think using

Social Security and Medicare to balance the budget, as you have indicated, Mr. Fawell, is just wrong.

Mr. **Fawell**. Right. All right.

Well, thank you. Obviously that can help me, the responses that you've had are what I've been accustomed to receiving. Everybody seems to be agreed upon one thing, that Congress went in the wrong direction when they zeroed in on the area of expanding that which Medicare has always been covering, and that is acute hospital and physicians services fees. So that is helpful and I thank each of you for your response.

Mr. **Tauke**. Thank you, Mr. Fawell. First of all, Mr. Johnston, I was very interested in your observation that senior citizens with incomes in excess of $13,000 are not losers under this bill. How do you define losers? Somebody who simply is paying more than they are receiving in benefits?

Mr. **Johnston**. That is basically it. And obviously, there are going to be some people who are really in the—not everyone over $13,000 is going to be in that situation, but on the average they would. But that's taking the combination of the increased Medicare supplemental premiums and the premiums out of their Social Security check, the net affect of any potential Medigap increases that you might have plus the out-of-pocket expenses that they are still going to pay. And when you add all those things and get an average, that's where we think the CBO data itself would draw the line.

Mr. **Tauke**. You indicated in your testimony that you have some suggestions for us and we appreciate those suggestions. Let me ask a few questions about it.

The first major thrust of that suggestion is that only 25 percent of the cost of Catastrophic Health Care Plan would be picked up by senior citizens. How would seniors pay that 25 percent? Would that be in the form of higher premiums, in the form of a surcharge, how would that 25 percent be collected under your plan?

Mr. **Johnston**. Well, under—there are only four ways that I can devise that senior citizens would end up picking up a share. And as I say, except for the poorer segments, and we think those can be covered with some buy-in, one is the State taxes, the supplemental premium that we now have in the law, straight premiums and straight premiums that we have and my mind slips on the fourth one, which is obviously not what we're proposing.

We think, given the negative reaction, and for those of us who have been fighting the Notch battle for so many years know how hard it is to make inroads in the Ways and Means Committee. Given the such fiery negative reaction that we've had through our lobbying efforts of the Ways and Means Committee members on the supplemental premiums, on the majority side, we have come to the reluctant conclusion that some of that supplemental premium may have to be kept so that Congress can say—what was the vote?

Mr. **Tauke**. What, in the House?

Mr. **Fawell**. In the House.

Mr. **Tauke**. 350 to 45, or something like that.

Mr. **Johnston**. Something like that. Five to one vote in the House in favor of this legislation. And as I think Mr. Fawell said earlier, you know, it's hard for those people to say they made a mistake. We feel that we may end up having to swallow some of that supplemental premium which we find odious, but we think according to our surveys if we can get long-term in-home care, that it may be worth it. And it may be the only way to get that in the current Congress. We'd love to have long-term nursing home care but that's going to be a bigger battle, that's going to really take some rethinking.

So we would like to see a more broad based tax. We think that the supplemental premium unfortunately may be the way to go.

Oh, the fourth option would be the increase in the taxation of Social Security benefits, of course.

Mr. TAUKE. What, where does the other 75 percent come from?

Mr. JOHNSTON. Most of that income would come from the additional tax on the top 5 percent of workers who earned more than $48,000 a year. Again that would get you $6 or $7 billion a year in the outset. And of course if that were extended to the entire Social Security portion, that would get another $24 or $25 billion. In fact, we propose that that should be done and that you reduce the general tax rates on workers.

Mr. TAUKE. So the one—is it 1.3 percent Medicare surtax, 1.4—

Mr. JOHNSTON. 1.44, 45.

Mr. TAUKE. 1.45 percent surtax, there would just be no cap on that?

Mr. JOHNSTON. Correct.

Mr. TAUKE. How do you gentlemen, Mr. Conger and Mr. Humphrey, how do you react to that kind of a financing proposal?

Mr. HUMPHREY. Why, I'm not that fast on figures. And when you're talking in the billions, that's way above me. I haven't even got a million myself. Why do you say, Conger?

Mr. CONGER. I'm going to say I gave up on the first million and I'm working on the second, but it's doubtful I'm going to make it.

Mr. HUMPHREY. Because that one comes easier.

Mr. CONGER. I concur. I mentioned long-term care; that's the feeling that the people had when I visited. But I'm sure that there are a number of them that in-home care is a vital part of their thinking.

But I concur on that financing part. I think that if we're going to finance it, if it's good for the goose it's good for the gander. It's good for everybody. If we've got to pay it, lower level, then it ought to go all the way through the system.

Mr. TAUKE. The idea that you mentioned, Mr. Conger, of a Part C for Medicare where people would have the option of buying in or not on the catastrophic provisions, that notion has, was kicked around last year when this was considered in Congress. If there were a Part C, do you think—how do you think that that should be financed? Do you think that the Part C should be financed totally by the premiums that would be paid, if you decided to buy in to Part C Medicare?

Mr. CONGER. That would be my feeling, that it would be—in other words, in the same way that we handle Part A and Part B.

Mr. TAUKE. Would there be—do you think there should be some mechanism for those low-income elderly who might not be able to afford to buy in to Part C, should there be some mechanism to finance their participation in Part C if we had a Part C Catastrophic Coverage Package?

Mr. CONGER. It would seem that that would be proper, yes.

Mr. TAUKE. Okay. Mr. Humphrey, I see you shaking your head. Do you have any observations on that?

Mr. HUMPHREY. The only thing, always it's bothered me that we spent, Congress and the government, have spent billions and billions of dollars in defense programs, in bombs and whatnot. But that's to kill people, not to save them. And I cannot see why that cannot be, a lot of it, eliminated. And there are a few getting very, very rich off of that program. Why cannot that be reduced and put in to the funds for the elderly or for the people? Most of the, as I understand it and as I see it myself, most of the money spent on arms and that sort of thing were obsolete before they were even manufactured.

So that really has never made sense to me. And even though we do have to protect ourselves from other countries and whatever, I don't think we need all of that spending. And particularly for, what was it, $100 for a hammer. Those sort of things. They enter into this picture. They still do.

And I think that the government has spent money, much more foolishly, on things that are unnecessary than they have on the elderly.

Mr. TAUKE. Mr. Johnston, you also made some mention about cost controls which of course is something that is not included in the current legislation. What kinds of costs controls would you like to see implemented to hold down the increases in costs, not only for the Medicare programs but also for the Medigap insurance that you indicated people are buying in the private side?

Mr. JOHNSTON. And that gets to one of the other areas Mr. Fawell was talking about, and that is physicians' fees. The reasons that Medigap—one of the things that is not addressed in the bill that we would like to see put in and we've advocated for for some time is something called mandatory assignment, which is in effect a process by which doctors cannot charge more than the Medicare-approved fee. Approximately 25 percent of all bills charged to senior citizens are approximately 25 percent above the Medicare-approved fee, and that is not even taking into consideration in this gap of $1,370 on the physicians—that we were talking about earlier—the bill won't help until you've got $1,370 of out-of-pocket fees. Well, you may get another $1370 that does not even get toted into the total there. So we believe that we'd be far better off with mandatory assignment than even this cap that's in the bill that costs so much money.

Another way of doing that is to work on physicians' payment reform, you know. There's been studies that have been done showing that, you know, specialists, surgeons, those kinds of things are getting reimbursed on a relative value scale of 40 to 50 percent more than the time and training and background that would be involved compared to a general practice physician, who may not be getting really enough. And that may be one of the problems for instance with the problems with rural health care, which are so critical, is that the payment scales for Medicare are out of whack. And we believe that if you would pay good regular physicians better under Medicare and less for specialists, you could bring down the total cost of the program for everybody, except of course the high price specialists.

Mr. **Tauke**. Gentlemen, we want to thank you for your testimony and also for all of the supplementary materials, which everybody in the audience does not get to see but a lot of work has gone into these supplementary materials and we thank you for that information.

Our next and last panel will be representatives of the Linn County Senior Advocates Program, the Iowa Committee to Correct Inequities in Social Security and Medicare, and the Heritage Area Agency on Aging.

If you could come forward.

I think we need another chair over there.

Watch out so nobody falls off the platform here.

Again, thank you very much for preparing testimony for us this morning. Why we don't begin with Shirley Henderson from the Heritage Agency on Aging.

Ms. Henderson.

STATEMENT OF SHIRLEY HENDERSON, SENIOR ADVOCATE, HERITAGE AREA AGENCY ON AGING

Ms. **Henderson**. Congressman Tauke, I would like to thank you for giving me this opportunity to share my perspective on the Medicare Catastrophic Health Coverage act as it pertains to long term care. During my testimony I will address two positive and one negative aspect of the Act.

In my position as a Senior Advocate for the Heritage Area Agency on Aging, I spend a great deal of time with clients concerned with long term care and health issues in general. The primary issues are financing long term care, nursing home placement and complaints, and hospital discharge orders as they relate to Medicare Diagnostic Related Groups, or as many of you know, DRG's.

During the past several years, I stood by helplessly and watched elderly couples, who thought they had planned well for their retirement, and they're struggling with the fact that their joint savings have been depleted to pay for nursing home care. It is difficult to comprehend the trauma and stress a spouse experiences when attempting to work through the financial maze of paying for the care of a spouse in a nursing home while also struggling with her or her own financial welfare. I am troubled by the fact that a spouse in the community will not go to the doctor, buy prescription drugs, have their eyes checked, buy new clothes or even repair a roof for fear of not having enough money to pay the nursing home. I have heard more than one spouse say, "I feel so guilty to even think about it, but what's going to happen to me when the money's all gone?"

The Catastrophic Health Care Act does cover this concern. Effective October 1st, the spouse of a Medicare-covered nursing home resident will be allowed to retain more assets when the assets are in the name of the institutionalized spouse. The spouse remaining in the community may retain a minimum of $12,000 or half the total assets, whichever is greater, but not more than 60. And the

States do have the option to increase that minimum to any amount up to $60,000.

Congressman Tauke, you may be interested in the fact that our Older Iowa Legislature's priority bill this year is asking the State legislators to increase that minimum from $12,000 to $60,000. The amount set will be determined by how much it will cost the State and what the legislature feels Iowa Taxpayers can afford.

Another section of the act which I feel very positive about addresses services and benefits to individuals who require long term home health care. As you may know, in Iowa the Heritage Area Agency on Aging has been in the forefront in establishing a Case Management Program. This program provides community-based services to the frail and vulnerable elderly in order to prevent inappropriate institutionalization. Case Management is a system which provides in-home services as a long term care alternative. We have a very successful Case Management Program in Linn County and are very pleased to learn the Medicare Catastrophic Health Act will: one, increase the number of days Medicare will pay for home health care; two, provide funding for outpatient prescription drugs; three, extend the hospice care and; four, provide for additional in-home respite services. These benefits will enhance our efforts to provide Iowa's frail elderly with long term care alternatives.

As I stated earlier, I do have a negative perspective on the Medicare Catastrophic Health Act to share with you.

I am often asked to counsel and advise families who have just been notified by hospital staff that a loved one no longer requires acute hospital care and must be transferred to a nursing home.

The family is usually given 1 to 3 days to locate a nursing home. If the patient is low income and qualifies for Title 19, the State will reimburse the nursing homes for the cost of that care. However, because nursing homes feel that the State reimbursement rate is unacceptable, they are very reluctant to accept Title 19 residents. Compound that with a resident that requires a higher level of care and you have a resident with very limited choices. Cedar Rapids residents facing this type of situation are discharged from hospitals into communities as far away as Waterloo, Independence, Manchester, Dysart. Why? Because nursing homes in this community are not available to them. At this point the resident has lost control of his or her life.

This problem creates a devastating situation not only for the resident but for the family. The resident is moved to an unfamiliar community and is completely dependent on those who provide the care. Family members because of the distance, other family and work commitments and/or health problems are not available to monitor the life of this residence. When I become involved in this type of situation, I see the resident and the family emotionally and physically drained and completely frustrated.

I am sure many of you in the audience today have faced similar situations. The decision to discharge a patient from the hospital is based on Medicare DRG's. Medicare determines the number of days the patient will remain in the hospital. If the patient is kept longer, Medicare will not reimburse the hospital. It is important to note that according to the Health Care Finance Administration, the average hospital stay for a Medicare recipient is 9.3 days.

Although the Medicare Catastrophic Health Act provides for unlimited hospital stays, only a small minority of Medicare recipients will ever qualify. How many Medicare recipients will actually spend more than 2 weeks in a hospital? Not many. Where will they go? The majority of those still requiring additional care will be transferred to nursing homes.

The Medicare Catastrophic Coverage Act provides for additional coverage for those requiring skilled care, but my concern is that Iowa has few residents residing in skilled facilities. According to the Sate Department of Human Services, the State of Iowa now has approximately 800 persons residing in skilled facilities. Now that's what the Medicare Catastrophic Act will cover. But we also have 31,000 residing in intermediate care facilities. The Medicare Catastrophic Health Act does not cover.

Congressman Tauke, the Medicare Catastrophic Health Coverage Act does not fully address this issue. Iowa has 31 individuals residing in intermediate care facilities and I recommend, on behalf of these individuals, that you place long term care high on your list of priorities.

In conclusion, the Medicare Catastrophic Health Care Act may not be the complete answer to health and long term care issues concerning many of us today. But there is some substance to the act. Congress is now contemplating some amendments to the Act which I support, but this process will place the bill in a very vulnerable position. When a piece of legislation is revised there is always the danger that some of the most beneficial sections could be lost in the process.

Congressman Tauke, I would like to take this opportunity to emphasize that we must stay alert when potential amendments to the Catastrophic Health Care Act are considered. As Mr. Humphrey stated, we certainly do not want to throw out the baby with the bath water.

Mr. Tauke. Thank you, Ms. Henderson.

Next, I would like to call on Joe and Beulah Rodecap. I'm not sure which one of you wants to go first. Joe, you're going first?

STATEMENT OF JOE RODECAP, CHAIRMAN OF THE IOWA SOCIAL SECURITY NOTCH GROUP, DES MOINES, IA

Mr. Rodecap. Well, Congressman Tauke, it gives me pleasure to thank you for the second time for an opportunity to speak here in this room. And I want to express the feelings of the Notch people in Iowa, which I happen to be the Chairman of the Iowa Social Security Notch Group. And we now have another concern, namely the Catastrophic Health Insurance Bill.

And as Representative Fawell made the comment earlier, he feels and I feel that you feel from expression, that I've heard from you that it is a mistake. And I can't help but think of a little report that my father gave me to many, many years ago. He said to my twin brother and myself that it's all right to make a mistake, but don't make it the second time. And I feel that we have made—I won't say how many—but I feel the Notch issue was a mistake for many people. I now think that this Catastrophic Health Bill needs some revision, some serious study, and I classify it as a second mistake that Congress has put upon the average American person which needs some rectification.

So I urge for the—to resolve that bill and try to come up with something that's more favorable to more people.

We, the Notch people survived the depression of the 1930's, served when we were called on in the World War II by the notice to draft, and then the congressional act in 1977 asked for we people to pay a big price for being born in a 5 year period. And now with this Catastrophic Health Insurance, it's just more than I feel that we're justified in being charged with. And it is estimated that only about 2,500 people in Iowa, of about 400,000 people, will receive any benefit from the Catastrophic Health Insurance.

Thousands of people realize the need of some kind of health care for the elderly. With hundreds of county homes for the poor being closed, something needs to be done for the senior citizens and people are living to be an older age. And we have been that we Notch people will be dead one of these days, and so we won't have to worry about you people. I hear some people getting up to about 30 years older than I am yet by the Today program with Willard Scott, so I've got some time ahead, I hope.

I and others have received letters from Congress and seniors with the information from the American Association of Retired People. This information, printed by AARP, came in regard to a letter about the correction of the Notch or adjustment to the reduction in the benefits. AARP material came in a postage-frank envelope and I question the congressional use of free postage mailing and enclosing brochures from organizations such as AARP. A few top officials of AARP didn't honor a survey taken by Robert H. Prisuita, Ph.D. back in 1987. The members surveyed were in favor of correction of the Notch but only 52 percent of the officials were in favor of the correction.

The American Association of Retired Officials lobbied for the Medicare Health Act of 1988. By pressure of AARP on the Congress, the Health Bill was approved. Many Congress people knew very little of what was in the health bill. The Congressmen relied on pressure of AARP, the largest senior citizen organization. The AARP membership however includes members at 50 years of age and up. I didn't feel just right to consider myself a senior citizen until I reached 65th birthday.

I feel the need to speak for people born after January 1, 1917, the Notch age people. Now Congress has put the burden of the Catastrophic Health Insurance of the senior citizens who are on fixed income. This is not being enough to burden with the increased Medicare premium and now our gracious elected officials—excuse me if I step on toes, but I know a couple of you are not in favor of this bill—have put this bill upon the senior citizens and placed a 15 percent surtax of all things on the senior citizens.

Have you elected officials ever thought how many times you have said, "Let us hear from you about your thoughts"? We now are asking that the Catastrophic Health Bill be revised so it will help more of the general public. With some consideration for correction of the reduced Notch benefit, any additional Social Security benefit could help the senior citizens to offset the catastrophic health cost.

And I appreciate your having this type of a hearing and not only wish more of our congressional people would do it in other areas. I'm not from this area, but I appreciate the opportunity to express the thoughts here.

Now earlier in the comments here I think I found something that made me lead to believe that Mr Tauke, you have uncovered something that would help compensate some of the cost. And I have got reference to that $58 billion that the Internal Revenue Service came up a record with, but the Social Security does not have any figures for. Now if I remember right, I think you happened to find that little error there. And I'm just not wondering for sure but I would like a little justification, maybe by chance did the Social Security use some of that $58 billion to come up with this complex of computer systems to keep up with the prescription drugs?

But it makes me think that somewhere Congress lost, and the Internal Revenue Service showed a report, that there should have been about $58.5 billion in our Social Security kitty somewhere. But maybe that's been lost by wayside.

I just feel that it is time that the burden has been placed on the people with a given income, that it's time something other than the total type of a catastrophic bill that has been put on us. I thank you for this opportunity.

Mr. Tauke. Thank you, Joe.

Beulah, would you like to share your thoughts?

STATEMENT OF BEULAH RODECAP, IOWA COMMITTEE TO CORRECT INEQUITIES IN SOCIAL SECURITY AND MEDICARE, DES MOINES, IA

Ms. Rodecap. Congressman Tauke, I want to thank you for giving me this opportunity to express my thoughts on the Catastrophic Health Insurance. I especially want to thank you, the only member of our Iowa elected officials, for casting a no vote on the Catastrophic Bill. And I'd like to thank you, too, Congressman Fawell, for your no vote.

In studying the catastrophic benefits, I question that the average person will receive any benefits from this bill.

As for unlimited hospitalization, under the present DRG or Diagnosis Related Group method of reimbursement and Peer Review Committee approval, it is difficult to be hospital confined for any length of time. Rather, patients are often dismissed from the hospital before they are well enough to be dismissed. The requirements for hospital admission under Medicare are: one, a doctor prescribes inpatient hospital care for treatment of your illness or injury; two, you require the kind of care that can only be provided in a hospital; three, the hospital is participating in Medicare; and four, the utilization review committee of the hospital or a peer review organization does not disapprove your stay. Prior to this year, a person under Medicare had 60 non-renewable reserved days which could be used for major and often terminal illnesses. This in most cases would be time needed by patients for a long or catastrophic illness.

It is estimated that only 1 in 32 will receive any of the new hospitalization benefits.

I made a call to the Des Moines Social Security office and Blue Cross/Blue Shield who administer payments for Iowa Medicare, to learn the number of skilled licensed nursing facilities in Iowa and mainly in Des Moines. Neither would give me this information and told me I would have to obtain it from my physician. I was able to get the information from First Call Help. At the present time, there are three skilled nursing facilities in Des Moines with 130 beds available. Also, Mercy Hospital has recently converted few beds from hospital beds to skilled nursing beds, mainly for patients from their hospital. In 1988, 100 percent of the cost for the first 20 days after a 3 day prior hospital confinement were covered by Medicare. In 1989, a patient must pay $25.50 per day for the first 8 days of confinement in a skilled nursing facility. The national average confinement in a skilled nursing facility is 8 days. And I might add here that if we'd have an epidemic in Des Moines, I'm afraid our skilled licensed facility beds will be mighty crowded.

The home health service is definitely needed, but not enough people are trained to render this service. This service could keep people in their homes longer, and help keep medical costs down.

The hospice care is also a much needed service. It is available if three conditions are met: one, a doctor certifies that a patient is terminally ill; two, a patient chooses to receive care from a hospice instead of standard Medicare benefits for the terminal illness; and three, care is provided by a Medicare certified hospice program.

The Part B of catastrophic insurance which covers doctors services, outpatient hospital services, home health care and various medical services will be available in 1990, after the deductible of $1,370 has been met. This is the $75 Part B deductible and a balance of $1,295, which is a 20 percent not paid by Medicare on approved charges. This would mean one would have to incur expenses totalling $6,475 before Medicare catastrophic insurance would 100 percent of all approved charges for the remainder of the year. And I'd like to stress here that is strictly Part B and not inpatient hospital charges.

The drug benefit becomes available in 1990, even though the increased premiums for catastrophic insurance are being paid in 1989. The deductible will be $550 in 1990 and drug benefits will be paid only on approved charges established by Medicare. The deductible will go up to $600 in 1991 and 652 in 1992. Because of the deductible adjustment each year, it is estimated that only 7 percent of people will benefit from this provision.

Under the hospice benefit, the patient is responsible for 5 percent of the cost of outpatient drugs or $5 towards each prescription, whichever is less. For inpatient respite care, the patient pays 5 percent of the Medicare allowed rate, approximately $3.25 per day in 1989. The rate varies slightly depending on the geographic area of the country.

We all know our Medicare premium was increased from $24.80 in 1988 to $31.10 for 1989. This is $6.30 and amounts to a 25.4 percent increase. In addition the premium increase, a surcharge of $22.50 for each $150 of Income Tax liability to a maximum of $800 for a single person and $1,600 for a couple is to be paid. These rates will be increased each year. By 1993, the Medicare premium is to be $42.60 and the surcharge up to $40.50. Keep in mind, if one pays income tax on an estimated basis, it is necessary to include payment for the surcharge. After 1989, one will be subject to a penalty by the IRS for not including the additional surcharge in their estimated tax payment.

One thing that upsets me about the surcharge is the fact we were encouraged to invest, and still are, in IRA's to be used as additional income for retirement when our income tax would be at a lower rate of taxation. Now when we use our IRA's we not only pay tax, but a surtax.

This year we were given a 4 percent COLA increase in Social Security. The other night when I was unable to sleep as I was thinking of the Catastrophic Bill and taxes, as an example who was receiving $500 in Social Security in 1988 would receive $20. Then $6.30 would go for increased Medicare premiums or 25.4 percent. If he were to pay only $22.50 surcharge for 1989 which would amount to $1.88 per month, it would leave a balance of $11.82 of the $20 Social Security increase. These two increases would amount to 40.8 percent of the $20 COLA raise. Also, many have experienced a big increase in premiums for supplemental health insurance. Our supplemental premium was increased by $23 a month or a 43 percent increase. All of these increases put a person nearer and nearer to the poverty class. And I might add here, we know there are many nursing home insurance policies available but with all of these other taxes, few are able to afford nursing home insurance. If one could afford nursing home insurance, it would help keep one from spending all their resources and ending up on Medicaid. Another thing; nursing home insurance premiums are not a deductible item for income tax purposes. Any way you look at it, it looks like a tax increase, hurts like a tax increase, angers like a tax increase, and it really is a tax increase.

Thanks again for giving me this opportunity to express my views on the Catastrophic Health Bill.

Mr. TAUKE. Our next witness is Joe Bolkcom, who is the Executive Director of the Linn County Senior Advocates.

STATEMENT OF JOE BOLKCOM, DIRECTOR, LINN COUNTY SENIOR ADVOCATES

Mr. BOLKCOM. Good morning. My name is Joe Bolkcom; I'm here this morning as the Executive Director of Linn County Senior Advocates. I'd like to begin by thanking you, Congressman Tauke, for your ongoing interest and work on health care issues and for holding today's Field Hearing in Cedar Rapids on the Medicare Catastrophic Act and related health care issues. I'd also to thank you, Representative Fawell, for coming to Iowa today to hear of our concerns.

I am here today representing the Linn County Senior Advocates, a coalition of 18 senior citizen organizations in Linn County representing more than 2,000 area seniors. The Linn County Senior Advocates has been very active in working for health care reform over the last 3 years. I'd like to do just a brief commercial. We just completed a project that I think might be of interest to some of the seniors here today. It's a comparative listing of prescription drug prices available at some 40 drugstores in Linn County, listing some 50 drugs. We left some on the table when we came in; if there aren't any copies available, they are available in the Public Libraries in Cedar Rapids and Marion, and they're in the March issue of the Over 49 News and Views which you can find at many of the grocery stores in Cedar Rapids and Linn County.

Personally, I've had the opportunity to work on health care issues from a senior citizen perspective over the last 8 years, working for three different senior citizen advocacy organizations in Iowa and in Illinois.

To date, our organization has not taken an official position on the Medicare Catastrophic Coverage Act. I think it's safe to say that our members hold a diversity of opinions on this act, so my comments today do not necessarily reflect one viewpoint about this issue, but many viewpoints. I would like to begin by outlining what is most significant and what we feel is good about the act, then talk about some of the problems, followed by some thoughts on where we should go from here to address some of the most significant and still unmet health needs of Americans.

The Catastrophic Coverage Act of 1988 represents the first significant improvement in benefits to the Medicare program since its inception in 1965. While not perhaps perfect, it represents the work and efforts of hundreds of concerned citizens to develop a plan that would begin to address the long unmet catastrophic health care needs of older persons.

While the act provides new benefits in several important area, I would like to focus on what I feel to be the most significant improvements. The first most significant improvements is the spousal impoverishment benefit. In the past, if a husband had to go a nursing home and the wife remained at home, the couple would be required to deplete almost their entire life savings and spend a majority of their monthly to qualify for Medicaid payments to cover the cost of nursing home care. This spend-down requirement literally impoverished the spouse at home. The Medicare Catastrophic Coverage Act makes significant changes in this area. The act curbs the spend-down of both assets and income of a married couple. Beginning in September 1989, it allows the spouse at home to maintain an income of 122 percent of the Federal poverty guideline. This provision will more than double the monthly income of the spouse at home. In addition, the at-home spouse will be able to keep a minimum of $12,000 in assets or savings, while individual States have the ability to raise the limit to a maximum of $60,000.

The spousal impoverishment benefit is really an income protection measure. It will finally allow couples with the unfortunate predicament of a nursing home separation to live out a more financially secured and dignified existence.

The next most important provision of the act is the so-called Medicaid buy in. Presently, our lowest income seniors living in poverty, who cannot afford to pay the Medicare premiums, deductibles and coinsurance, go under the State Medicaid program to receive health care services. Not only has this proven to be very expensive for the State of Iowa, but it has meant that these seniors have not received the same level of services that other seniors have received under the Medicare program.

The Medicaid buy-in provision requires State Medicaid programs to pay the Medicare premiums, deductibles and coinsurance of poverty level seniors. This provision will assist almost 3 million seniors in receiving a much higher level of service presently enjoyed by their peers in the Medicare program.

While I could talk on about other benefits in the act that provide real and substantial benefits to my senior friends, I think that I will just say again that it's no small accomplishment to add major new benefits to the Medicare program. They were obviously a long time in coming, and while not perfect they do represent a positive step in improving the financial security and the health of our older population.

I would like to talk now about some of the concerns that seniors have about the act. The first concern is that the act provides no provision to address the most significant health care concern of seniors; namely, the ever increasing cost of health care services. The Act provides no cost containment mechanisms. This is not only detrimental to individual senior who cannot pay the leftover bill from an unassigned physician claim, but places a significant hardship on the Medicare program as a whole. The lack of cost containment has a direct impact on the next and most vocalized concern about the act. And that is, how these these new benefits are going to be paid for.

For the first time, seniors have been asked to shoulder the entire cost of new Medicare benefits through an increase in the basic premium and a new surtax on income. For obvious reasons, many seniors are upset about having to pay new taxes for services they hope they will never need. Previously, all seniors paid the same amount for Medicare deductibles, including copayments, and the same dollar percentages. No matter if you were a married couple with an annual income of $10,000 or a married couple with an income of $50,000, both couples paid the same Medicare Part A deductible. Today, we retain that approach. However, with the Catastrophic Coverage Act we say to seniors that have greater incomes they should pay more than seniors with lower incomes for these benefits.

Obviously, this concept has upset many seniors, particularly those with higher incomes who will pay these new taxes. I would like to point out some statistics that provide some detail about who actually will be paying for the act in 1989. Of the Medicare beneficiaries who are single, mostly which are women, 66 percent will pay only the basic premium. Twenty-one percent will pay the basic premium plus $250 in surtax, while 12 percent of single Medicare enrollees will pay the basic premium plus anywhere from $250 to $800 in additional surtax. For married couples, almost 50 percent, 47 percent pay only the basic premium. Twenty-seven percent pay $250 each, while 25 percent of married enrollees pay anywhere from $500 to $600 in additional taxes in 1989. Drawing conclusions from these figures will depend on where you come down in regard to this supplemental tax. Half of married couples and two-thirds of singles enrollees will not pay the surtax. However, a large number of seniors with more substantial incomes will pay the surtax.

While clearly the financing has been the most controversial aspect of the act, it must be viewed in light of a number of other significant problems. It is understandable that higher income seniors are upset about the new taxes; no one likes to pay more taxes. However, the 30 million Medicare beneficiaries as a whole not only wanted and needed more comprehensive Medicare benefits but will be better off because of the Catastrophic Coverage Act. Medicare beneficiaries presently enjoy perhaps the most comprehensive health care benefits of any group in our society, and while they do pay a growing percentage of their incomes for these services, there are many other groups in America that do not have even basic access to health services. With 37 million Americans and 350,000 Iowans with no health insurance whatsoever, I think seniors need to recognize the kind of intergenerational problems created when other groups' health care needs go unmet while many of ours are routinely taken care of. It is imperative that we remain sensitive to the needs of our peers, but it is equally important that we not lose sight of the broader issues that face our health care system and the right and ability of other citizens to equal access to health services.

I would finally like to talk about what needs still remain unmet, and we've heard a lot about those already. They can cause real catastrophic impacts on the lives of millions of Americans. And that is the need for a comprehensive long-term care system. While the Catastrophic Coverage Act provides improved protections, it does not meet the long-term care needs of seniors. Namely, extended nursing home coverage or adequate in-home care services. Many seniors thought and still do think that the Catastrophic Act deals with these matters. However, it does not. I think if it did, it would have enjoyed a better reception in the senior community.

Long-term care refers to services provided over a long period of time to persons with chronic illnesses who need assistance with regular, everyday activities such as eating, bathing and getting dressed. It generally does not involve a doctor or hospitals and can be provided in the home by a visiting nurse, in the community at an adult daycare center, or in an institution like a nursing home.

Recent poll data indicate that over 60 percent of the American public have some experience in their own families or through close friends with the need for long-term care. Long-term care is a family issue: It is the grandfather with Alzheimer's Disease; a husband or a wife who has suffered a stroke; a worker in the prime of life disabled by an accident; a grandmother immobilized by a broken hip; and a child with cerebral palsy. Long-term care is the most devastating health care expense for older Americans. Precise estimates of the costs of long-term care to older Americans—I'm sorry, to American families are not available, but the cost of caring for Alzheimer's disease patients alone exceeds $40 billion annually.

In 1987, nursing home care for the elderly cost the Nation about $41 billion. Of this total bill, families and patients paid 51 percent, or about $21 billion, directly out of their pockets. Another 41 percent was paid by Medicaid and only 2 percent was paid by the Medicare program.

Almost 5 in 10 elderly living alone will spend down their income and financial assets to the poverty level after only 13 weeks in a nursing home, and over two-thirds of those same elderly will do it in less than a year.

Care provided at home by a professional caregiver costs an average of $45 to $60 per visit and $50 to $200 per day.

There is almost no public insurance coverage for long-term care. Medicare covers less than 2 percent of long-term care costs and private insurance only about 1.4 percent. Medicaid is available only to the impoverished and then generally, for only nursing home care.

Families are being stressed beyond their capacity because of the emotional and financial strains of providing long-term care.

A system of long-term care services should be available to all who need them, regardless of age or income. The financial risk from long-term care should be spread as broadly as possible through a social insurance program like Social Security or Medicare.

A national long-term care program should provide a comprehensive range of facility-based and community-based health and social services. The program should assist, not replace, families and other informal caregivers.

The new public program should be supported by sources of financing that are as progressive as possible. Recent national poll data reveal that Americans want the government to step in and help solve the long-term care problem with a program like Social Security or Medicare and they say they are willing to pay higher taxes for such a solution.

Finally I appreciate the opportunity to testify here today to share our concerns and encourage your continued work in these important matters. Thank you.

Mr. **Tauke**. Thanks to all of you for your testimony. It's evident that a lot of research has gone into some of the testimony we received today.

Congressman Fawell, do you have questions?

Mr. **Fawell**. Maybe a bit more comments than questions, but Mrs. Henderson, I noted that in your comments you, when you stress the good points in the bill, you referred to the in-home health care, the respite care, the spousal impoverishment. And I would certainly agree with you. It seems to me that you're basically joining what has previously been said, that—I know that no one has thus far praised the basic thrust of the bill, which of course is the expansion of hospital and physician and then the prescription drug addition. And that seems to be very significant to me that when one looks at what we've done in in-home health care, basically we're talking about a continuation of acute hospital care but following the patient out of the hospital, the sicker but quicker syndrome under the DRG program and so forth and so on, and certainly improvement has been made there. But it hasn't been very much of an improvement, has it?

Ms. **Henderson**. I think that many of the people that are coming out of the hospital are not receiving home health care. I know in our area we've grown to some extent, but the majority of people being discharged are going into nursing homes and sometimes that's an inappropriate placement. They could be in their homes if the services were there.

Mr. **Fawell**. The irony, it would seem to me, is that as—and I think the PPS program and the DRG's designed to control hospital costs. And it's been relatively successful, but the irony is that it ends up with more being pushed into custodial nursing home care and that Medicare basically isn't helpful at all.

And for those who can use the extended in-home health care, you need a physician's certification, which means we're still talking about if you need more acute services that the hospital isn't going to render any longer because they can only keep the patients for so long, theoretically—well, not theoretically, they can keep them for a time period greater than the number days authorized but as a practical matter, they certainly don't. So you have an increase of those who need subacute, that is physician certified services after they get out of the hospital and even with the improvements here, we haven't made, we haven't gone too far. And it's tough to get that approved by the Medicare people. So it seems to me that the first three to testify, you basically are saying what has been said before. If we're going to have these improvements, we should have gone in the home health care area or in the long-term custodial nursing home care area.

Mr. Bolkcom, you are the first one that I've heard today that has basically defended the basic thrust of the bill. You have said, I hope I'm not misquoting you, that however 30 million will be basically better off with these benefits. And I guess one would have to say that in general that is true. Whether or not the, pouring all that money into those benefits though I question when you then understandably go on to lament that the roughest area apparently is the long-term care provisions, which we aren't solving.

And my question would be, as I have questioned some of the others, we don't have the luxury of being able to cover all of the basic parts of the delivery of health care services to seniors or the general populace. But as we talk about seniors, when we talk about the acute care, hospital and physician care, and then in-home health care and then long-term custodial nursing home care. Would you not agree that if we're going to spend some $31 billion over the next 5 years—and that's just for starters—and recognizing that the government or whatever financing program we have, we cannot cover 100 percent of the costs certainly of long-term custodial care, wouldn't you agree that that's, if we could make only one choice in regard to expansion in reference to the three that I have referred to, that perhaps the better way would have been to zero in on long-term custodial nursing home care and/or in to the in-home health care?

Mr. **Bolkcom**. I think that the Catastrophic Coverage Act meets some real needs of seniors. And I think it wouldn't have received the support it did unless it provided services that were really—you know, we debated the Catastrophic Bill for several years now and the addition of services for several years. And I think the provisions of the Catastrophic Coverage Act would not have received the support they did unless they were going to meet people's true needs.

I think that additionally—

Mr. **Fawell**. I might question that; an awful lot of people didn't read the bill before they voted on it.

Mr. **Bolkcom**. Okay. Additionally though, in terms of the long-term care issue, I see the long-term care issue is a much greater issue than just a senior issue. I see it as a family issue.

Mr. **Fawell**. Absolutely.

Mr. **Bolkcom**. If a person in this room requires nursing home care, many times the children of that elder are going to come in and either try and assist that person to stay in their own home and put resources into it, or pay out of their own savings account to make sure that Mom or Dad has the kind of nursing care they need. Or if it's in-home, the same thing. And I think that to develop a system patchwork of programs and a Band-Aid approach becomes very, very expensive administratively, and I guess what I would propose is that we look at the long-term care needs not just of seniors, but of other disabled Americans, persons that are mentally retarded, persons that have—young people that have a car accident are disabled for their entire lives. And that we try and address in a comprehensive way a long-term care system that not only meets seniors' needs, because they have long-term care needs, but meets the needs of other Americans.

Mr. **Fawell**. Well, I would agree that's the best of all worlds. There comes a time when the money just isn't there and someone has to be able to say, from whence that money will come. When you're dealing in quarter of a trillion dollars, a brand new debt that we're pouring upon the children of this Nation, our future citizens, one generation just kind of leaves a whole lot of other debt for other generations and we're not doing anything about that. You just don't have those druthers. You have now a situation where we are committing ourselves to say $30 or $40 billion in regard to expanding Medicare, but basically not in the areas of in-home health care and not in the area of long-term custodial nursing home care which I agree completely with you statement when you point out that this is a real, total family problem. The psychological trauma that every family faces is immense. Not to mention the financial.

I come back to the question that we have to be practical in the sense of we have only so much money and now we are talking only about seniors. It would be nice to cover the whole area. Do you feel that Congress having only those decisions of having to go one area, did we make the right choice in doing what we did?

Mr. **Bolkcom**. Are you—you're asking me whether we should look at home care or nursing—

Mr. **Fawell**. By ignoring totally—now we may not have any funds, for instance to even think of helping an in-home health care, now. Because we've usurped them and utilized them all in another area.

Mr. **Bolkcom**. Well, we are paying some costs right now. I mean there are some resources being spent out of pocket by families all across the country for home care services and for nursing home services, and for the catastrophic services that seniors presently, prior to the Catastrophic Act, didn't have coverage for. So there are some resources out there. I'm not sure I can put my foot down on one specific approach. The Catastrophic Act obviously meets people's needs. I'm not sure—I mean, if we take away from those, the needs it covers to cover something else, we're going to have, you know, people having catastrophic health care needs that go unmet.

So it's hard for me to say we should meet some peoples' needs while not others.

Mr. **FAWELL**. Thank you very much. And I thank the panel.

Mr. **TAUKE**. Thank you, Mr. Fawell. For those who are interested in addressing Congressman Fawell and myself, we will take comments from that microphone right after this panel. I have a couple questions yet for this panel, however.

First, a couple of you during the course of the morning have mentioned the cost of Medigap insurance going up. And one of the arguments in favor of this bill is that it would permit Medigap insurance rates to go down.

We've heard, I think two reports of Medigap insurance going up over 40 percent. From your experience, Mr. Bolkcom, Ms. Henderson, is this fairly indicative of what's happening across the board, or do you have any feel for what's happening to Medigap insurance rates this year?

Ms. **HENDERSON**. I can just testify to what I'm hearing the senior citizens in our area saying. And if any of you out there agree with me, I've heard that Blue Cross has dropped their supplemental health insurance premiums to some extent in the last couple of months. Is that true?

[A chorus of noes.]

Ms. **HENDERSON**. That's what some of them have told me. So other than that, that's all I've heard.

Mr. **TAUKE**. I was pretty surprised to hear about these huge increases, I guess. That's why I'm raising the question.

Mr. **BOLKCOM**. We've been meeting with the Iowa insurance division working on another project and brought those questions up and they indicate that we are going to see an increase in the premiums for Medigap policies even though less protection is provided. And one of the explanations was that they're just going to be doing some catch-up in that they weren't, some of the insurance companies in the ratio of the premium to outpay, wasn't up to what they thought it was in previous years and that they have an opportunity now to make some ground.

It's unfortunate I think, because it's kind of a double whammy.

Mr. **TAUKE**. Mrs. Rodecap?

Ms. **RODECAP**. I have been told of one insurance company that is no longer offering insurance, Medigap insurance, to individuals. They've gone strictly to group only. And I do know that they had a big increase in their premiums.

Mr. **TAUKE**. I think that that is all that I have to ask this panel. I want to thank you very much for your testimony and your willingness to come before us this morning.

Now, let us move to the next phase of our hearing this morning, where we allow those of you in the audience to offer your observations. Could we—when you come to the microphone if you would state your name and then we'll let you offer whatever observations you would like. I would encourage each individual, however, to keep their comments relatively brief to accommodate all of those who are here. Go ahead.

STATEMENT OF PAUL JAUCER, DES MOINES, IA

Mr. **Jaucer**. Congressmen, I am Paul Jaucer from Des Moines, Iowa. I have 90 years of experience to state; I'll be very short.

This bill was passed by a Congress that has mostly become a ruling class. They have no compassion for their constituents. Formerly our government was governing of the people, by the people and for the people. Today, it is of the people, by the lawyers and for the rich.

Neither a Congressman nor a Senator should be allowed to serve more than two terms with no pension except Social Security; the same as the rest of us. If this was the law, there would be no Social Security Notch today, there would be no unjust attempt to assess elderly people more of their money, that they paid all of their lives. They went through the depression, then went through the war, they survived all that. And we will survive this, one way or another.

With that, I guess I will let somebody else speak. Thank you.

Mr. **Tauke**. Thank you. Next?

STATEMENT OF ANN KUBATZ, CEDAR RAPIDS, IA

Ms. **Kubatz**. Hi, I'm Ann Kubatz and I'm from Cedar Rapids. And I listened to Mr. Tilghman talk about this new bill, okay. And it sounds good when he gets up and tells about it. But when you come down to the nitty-gritty, we find that only about four-tenths of 1 percent will benefit from provisions allowing for the hospice stay over 60 days; that's not very many. One out of 14 from the expanded physician coverage; that's not very much. And then only one out of six are going to be able to use that drug coverage. Well, how does that help us?

But the bad part is they extended coverage for the disabled. Well, that s fine. Except this is going to include, I believe, the AIDS patients and we know how those are increasing, we know how the carriers are increasing. Yet all of that cost comes on us. And if we're going to help the disabled we should spread it out, everybody should help the disabled.

And I listened to Joe Bolkcom and he says that he thinks that this meets our needs. Well, this doesn't look to me like it's meeting our needs. But then he's not old enough to have to pay for it, so maybe he can agree with it.

That's all I've got.

STATEMENT OF BETTY DALES, GRINNELL, IA

Ms. **Dales**. I'm Betty Dales from Grinnell, Iowa and I would just like to state that I would ask you to please support legislation to rescind this catastrophic surtax. It is not only discriminatory, but it is baleful, sinister and deadly discrimination against just one category of age 65: those who have to pay the surtax.

By the time we pay the surtax and all the deductibles we are responsible for, we are brought down to the level of what is considered poverty level.

STATEMENT OF LEO MORRISEY, CEDAR RAPIDS, IA

Mr. **Morrisey**. Congressmen, I'm Leo Morrisey, I'm from Cedar Rapids here. Shortly—or about the time this bill was passed, Congress saw fit to include AIDS patients under Medicare, Medicaid. I don't remember them making any provision for funding on this. Are the older people supposed to pay for that, too? At the rate of about $100,000 apiece? Also—

Mr. **Tauke**. Let me, if I may, just address the AIDS patient question. AIDS patients do qualify for the Catastrophic Health Insurance Bill if they become disabled, if they meet the disability standards of the Social Security Act. And of course, as the various drugs that prolong the life of AIDS patients are developed, there will be more and more of them who will qualify for Social Security disability. And it is true, as a result, that some of the benefits of the Catastrophic Act will go to AIDS patients.

And I don't have any problem with providing funding to care for the AIDS patients, but I don't think the cost should be borne by senior citizens alone.

Mr. **Morrisey**. Thank you.

Mr. Bolkcom also said that there were a large number of people in need of medical coverage. For his age, I can see where he doesn't have much problem with this. Working as a young man, he has to have a heck of a good income to even consider helping his aged parents to maintain their home, medical coverage and so forth. I think it's wrong that these people, this age group, is expected to cover everything. And that's what this bill says: you've got it, you pay for it. That's wrong.

Mr. **Tauke**. Thank you.

STATEMENT OF GRETCHEN WALDER, SENIORS OF THE COALITION AGAINST THE CATASTROPHIC ACT

Ms. **Walder**. My name is Gretchen Walder, and I'm representing the Seniors of the Coalition Against the Catastrophic Act. I have in my hand a petition that was sent to me by David Halley from Nevada, and he is also very much in favor of Mr. Fawell and his opposing the Catastrophic Act. Congressman Tauke was not mentioned, however.

I also have a petition that was sent in to Congressman Tauke; I don't know whether you ever saw it or not, but it was sent from our group where we live. There's 117 signatures on it.

If anybody would like to have any copies of this petition that can be sent in. As of this date that I've got it, there were 18,650 names. And there was also an average of 150 to 200 names a day coming in to Mr. Halley's office in Las Vegas. So if anybody is interested, please get a hold of me. I'll be right over here in this area, and I'll be glad to talk to you.

Thank you.

Mr. **Tauke**. Thank you.

STATEMENT OF OTTO MUELLER, CEDAR RAPIDS, IA

Mr. **Mueller**. I'm Otto Mueller from Cedar Rapids. I would like to suggest to the National Committee to Preserve Social Security and Medicare, if they want to get this bill upset that they use some of their publicity to say out to everybody, as they do when they want some money, and say, "Put the pressure on the Congressmen like you did when you didn't like that automatic raise in the Congressmen's wages."

Number two, I have a question. I can buy nursing home insurance from my company for approximately $1,300 a month or something like $16,000 a year. This—I don't know how long, I'm 72, I might have to pay for 10 years, I might only have to pay for 3 years. But taking the nursing home expenses would be somewhere from $18,000 to $30,000 a year. The increase is taxable; the gain of life insurance and so forth policies is taxable as you receive them. Am I going to have to pay taxes and surtax on this nursing home support that I would get from this insurance company?

Thank you.

Mr. **Tauke**. We're trying to figure out how to answer your question.

Mr. **Fawell**. I assume you're talking about insurance proceeds that would help you finance nursing home stays. Is that your question?

Mr. **Mueller**. Well, the IRS a few years ago wanted to tax the internal growth on tax deferred annuities and on life insurance policies, which thank God somehow it was stopped.

Now, as I have a—I don't have it, but I say I can obtain a life insurance policy—a nursing home policy that will pay the total bill. If this amount that is over and above the premium I paid in, is this going to be taxable and surtaxed? Like the increase in my—when I start drawing on my life insurance, a certain amount of that is taxable because it is growth.

Mr. **Tauke**. My understanding is if this is a nursing home insurance policy, that then your benefits would not be subject to taxation. If this is an annuity or a life insurance policy, where you can then use the benefits for some other purpose, then the potential exists for taxation, for you to have to pay taxes.

I guess we'd have to know a little bit more about specifically the kind of policy that you're talking about to know whether or not you would have to pay tax.

But if you pay income tax on it, then you also are subject to the extra tax, the tax on a tax, that is contained in this legislation.

Is that a fair—okay.

If you want us to take a look at that particular proposal or that particular policy to see whether or not we think it's subject to taxation, we'd be happy to. Although we aren't experts necessarily on all the details of the Tax Code.

STATEMENT OF DOROTHY CONNER

Ms. **Conner**. I'd advise the previous man to invest his $18,000 in some other way.

I'm Dorothy Conner, I do volunteer work with senior citizens in addition to being a tax preparer.

Several of my questions have been answered. But the majority of people that come in for tax preparation, do not yet realize there is going to be a surtax. And the ones—I mean as I prepare their estimates, everyone is quite astonished to say the least.

One of my questions here, after listening to some of these people—or the problems that I have gathered. Doctors in small hospitals going out of business because of Medicare's rules and restrictions. Shirley Henderson made it sound like home health care is good, but you get out in the rural areas we do not find people trained in home health care and Medicare is going to insist that these home health scarers are trained. So out in the rural areas there is no home health care. My mother needed to be hospitalized or needed help and we spent over a year trying to get some help to come into the home. And if someone does come in, that 1 hour a day that this nurse comes in to check, what goes on for the rest of the 23 hours a day? So most of the people that need help need to go into a nursing home or some kind of facility.

And then if you do get into the nursing home, well, I think somebody mentioned it's only about 2 percent of the care is covered by Medicare. And the lack of nursing homes that are Medicare supplied or covered by Medicare are too few.

About prescriptions. Can anything or has anything ever been investigated about putting a freeze on prescription costs? I mean, what good will it do to be covered if the cost goes up every year, more and more and more?

I guess the rest of my questions were covered.

Mr. **Tauke**. Thank you for your comments.

Let me just observe that there is a great deal of attention being focused on the problem of reimbursement to rural hospitals and physicians. And Congressman Synar from Oklahoma and I have had a coalition of about 100 Members of the House, over 100 Members now in the Rural Health Care Coalition, and we are—will be in March, later in March, introducing a whole package of legislation dealing with rural health care problems in particular, and those reimbursement rates will be the subject of much of that—of our attention.

Yes, sir?

STATEMENT OF GORDON MARTIN, MT. VERNON, IA

Mr. **Martin**. I'm Gordon Martin from Mt. Vernon, Iowa. And my question concerns filling out our own individual tax forms. Many people retired and living on their retirement income, don't pay taxes; however they have a spouse working who does pay taxes. It's more beneficial to file jointly. But then that surcharge, will that be taken from the spouse's income and how will the surcharge be figured where a spouse not 60 years old is the only taxable income in the family?

Mr. **Tauke**. That's a good question; you do have me. Maybe our expert here from Health Care Financing Administration, if you could just speak to that question.

Mr. **Tilghman**. What will happen, you've got two situations. One is where the one you've mentioned, you've got one spouse is on Medicare and the second one isn't. In that case—I'm not an IRS expert, but what I've read on the law because of the publication, IRS Publication 934 that explains all of this—that you'll take the total income for both the working and the non-working spouse, divide that by two, and then half of that total income is what you'd base the supplemental premium on for the Medicare beneficiary. It's the same thing when you've got two spouses or a married couple where they're both eligible for Medicare, then you essentially take their total income and the maximum premium would go up double, from $800 to $1,600 in 1989.

Does that answer your question?

Mr. MARTIN. So then that would make the maximum premium half of what—

Mr. TILGHMAN. In your case for example, you would take half your total income, whatever your income and your wife's income, divide that by two, and then your maximum premium for this year would be $800 on half that total income for your family.

Mr. MARTIN. Yeah, okay. So she's really paying all of it anyway.

Mr. TILGHMAN. Probably. In your case, it could be that way.

Mr. MARTIN. Thank you.

Mr. TAUKE. Next, please.

STATEMENT OF JEAN JENSEN, ANAMOSA, IA

Ms. JENSEN. My name is Jean Jensen and I'm from Anamosa. And I have two questions. And the first one is, how could Congress approve this lower rate for this so-called Notch year recipients for Social Security and then, as Mr. Fawell admitted, they borrow from Social Security funds for other purposes and yet they have never rectified the Notch year problem?

Mr. TAUKE. I hesitate to plunge into that issue. Let me just observe that that happened before either Harris Fawell or Tom Tauke got to Congress.

The situation is essentially that when Congress, as Mr. Rodecap pointed out earlier, made some mistakes. In 1972 in passing Social Security legislation one mistake was made, and then they attempted to correct it in 1977 and, at least in my view, another mistake was made and that created the Notch. And the Notch is an example of Congress attempting to look to the future and make some judgments as to how the inflation figures will—how inflation will develop and some other estimates as to what will happen, and then attempting to make policy on that basis. Well, things didn't work out as they planned so as a result those born between 1917 and 1921 have lower Social Security benefits than I think Congress intended, and they are subject to what we call the Notch.

Why doesn't Congress correct it? Because we don't—in simple terms, there aren't enough votes to do so. We've got about 185 out of 435 Members in Congress who are willing to address the issue at the current time, and that's short of a majority. And so we are stymied in the ability to try to go back in and correct the Notch problem until we get more support.

Why are the Social Security trust funds—let me just speak to that a minute. The Social Security trust funds are generally secure in this sense: That Congress can't rob money from the Social Security trust funds and fail to put it back. We have, through the passage of legislation, essentially prevented the Social Security trust fund money from being used directly to finance general fund activities. However, the fact is that when these surpluses build up in the Social Security trust fund, those are surpluses are then invested in

U.S. Treasury Bonds. And the U.S. Treasury Bonds, obviously, then are used to finance the other activities of government. When we borrow money at the Federal level, we're borrowing it in part from the Social Security trust fund.

Now all of that is well and good, except sometime down the road somebody's going to have to pay all of that back to the Social Security trust fund. And in order to do that you will have to be able to borrow it from someplace else, refinance the debt if you will, from someplace else in order to pay back the Social Security trust fund.

Now, that problem won't arise until about the year 2025 or 2030 when the surpluses will be drawn down and we will begin to run a huge deficit in the Social Security trust fund. That's when the refinancing will have to take place. And by my calculations I'll be about 75 or 80, if I'm still here, and probably relying on Social Security.

In any event—so that's the problem. It isn't that in the books that we're borrowing from the Social Security trust fund, it isn't that the money isn't there from an accounting perspective, but obviously somewhere down the road the U.S. Treasury is going to have to be able to refinance that debt in order to pay the Social Security trust fund back.

Now, if you aren't totally confused yet then—

Ms. JENSEN. Okay. My second question, while I'm some years from Medicare I'm wondering what precepts Congress used in determining these—this thing, because private insurance companies will offer you a choice of plans and it seems to me like Medicare ought to be the same way. With a $200 deductible, maybe $250, $300, on up to as high as maybe $700 or $800 now anymore.

And when you have an adequate retirement insurance coverage through your work or whatever plus some additional supplementary coverage that you pay for on your own and the present Medicare program, why do we have to be forced in to this other? Granted, maybe sometime down the road a lot of us are going to need that catastrophic care. But, it just—I don't know. I have a hard time with this fact that we don't have any choice; that when you become 65, automatically you are put on Medicare and you are charged for Medicare. I guess I just feel that we still need to have a choice. It's almost like we're forced into it, and I don't think the government should be forcing people to do anything. It becomes too close to dictatorship to suit me.

Mr. TAUKE. I personally believe that that is one of the major problems we face in our health care policies at the Federal level, and that again goes well beyond our discussions here this morning. But I do serve now on a Commission that consists of six Members of the House, six Members of the Senate, and three representatives of the administration that is chaired by Congressman Claude Pepper. And that commission, which organized a few weeks ago, is to look at two issues: One, health care for the uninsured; and secondly, long-term health care coverage for nursing home care. And when you look at those two big issues and the big price tags attached to them, you have to look at the whole health care delivery system and all of our health care policies. In doing so, I think one thing becomes clear. That we have a problem with our current health care services—I should say our current health care policies, because they are so inflexible and don't respond to the differing needs of different groups within the population that is covered. And I am one of those who believes that we need to look at the possibility of the Federal Government sending money—instead of sending it from the Federal Government to the providers of health care services and then saying to every recipient, "You fit into that nitch"; instead, we'd send the money to the purchasers of health care services, the patients if you will, and then have them have the option of purchasing an array of qualified health insurance plans. So you could purchase maybe the $100 deductible plan, or the $300 deductible plan. There would be certain standards that would be set so the Federal Government would be assured everybody had basic coverage, but you would have some options on that purchase.

So that's kind of a big picture issue that is going to have to be addressed, I think, sometime over the next several years as we attempt to make some sense out of our health care policies.

Ms. **Jensen**. Well, it seems fair. Now like, for example, in this doctor outpatient care, the Medicare recipient has to pay $1,370 per year before he qualifies for any remission from the Medicare. And that's just on doctor and outpatient care.

Then there's there so much you have to pay for drugs, so much—you know, and that amounts to a whole lot more than say even $700 or $800 deductible in a year for the whole thing.

Mr. **Fawell**. Yeah. I think you have hit on one of the basic elements of this bill and why I have a lot of trouble and I think why a lot of people have a lot of trouble with it. Congress has a right to set policy for instance, without giving much thought to the thoughts you're expressing, when all of the taxpayers are providing the money. Then we set social policy and we believe this is the kind of a program, as initially Medicare was—it was presented by Congress and basically the general taxpayer was supplying the funds.

What Congress has done now is gone into this mandating vogue to which I made reference; they're now saying no, a certain group of people shall come up with the wherewithal to be able to finance various new social programs. And they're forgetting that when they do that, when they say to the seniors that you're going to have to pay for this, not only are you going to have to pay for it but you're going to have subsidize others, too, who cannot pay for it. They have forgotten that when they do, then they do have to ask the senior, "By the way, what do you want? What is your need?" And those who are asked to pay specifically, then I think pass an obligation on Congress to have the particular policy as in this case not be one policy that supposedly is good for all, including those who are not even paying, but they have to dovetail it, as you have indicated, to the needs of the people who are paying. And they're forgetting this.

And I think Congress has to recognize that when you're going to mandate benefits and expect a certain group to pay, that's quite a big difference from mandating benefits when all the people are paying. And I don't think Congress is aware of this, or giving thoughts to this. Thus people like you are saying, you know, "what you're giving me is not something that fits me; it may fit the person down the street who does not pay any income taxes whatsoever," and so forth and so on, but you're saying, "I have a policy, I have an employer-provided policy, I have Medigap," and so forth and so on, "and it doesn't fit me." So it isn't fair; it's a dictatorship. And I empathize with where you're coming from. But Congress has to recognize this, and I don't think Congress has.

Ms. JENSEN. Maybe next time, go to the people first and get their opinions. Thank you.

Mr. TAUKE. Thank you. Yes, sir?

STATEMENT OF LIONEL PATTERSON, CEDAR RAPIDS, IA

Mr. PATTERSON. My name is Lionel Patterson; I live in Cedar Rapids, Iowa. I have just gone through the experience of losing my wife to cancer, tumor, and we made use of this home health service. We found it very effective, much cheaper than if she had to go to a nursing home, and I feel she got better care. We had nurses aides who came in in the morning from 7:30 until 10:30, and then a different one who came in in the evening from 6 o'clock until 9 o'clock to help take care of her health needs and other needs that went along with it. And I can attest to the fact that it's a very good thing.

But unfortunately, there's no Medicare or any other insurance that covers that sort of service. And that's one thing that I think is very, very important because if people can take care of their ill spouses, in their own home, they feel much happier about the whole thing. And we feel that that was worth something.

Now, I have Medicare but I have also paid in for other health insurance over the years. And fortunately, we were able to survive this. But it cost us $16,000 for the home health aid that we had from March 16th until December 19th, when she did.

Now, one of the problems that we have in connection with the health service as it exists now is that complicated measure of how these bills are put out. Some doctors send them direct to Medicare; some don't send them direct to Medicare; Medicare sometimes sends them back, the results, quickly; sometimes it's months before you get the results that they come from. And it takes a person who's an accountant to keep up a set of books to just keep up with all this, and if you've got many, many different doctors: anesthesiologists and radiologists and pathologists, all sending in bills at different times, you can't keep them all straight. Because some doctors send it direct to Medicare and you don't even know what the bill is until you get something from Medicare. And in one case we had two operations and they got the anesthesiologist mixed up in their billing and it took a long time to straighten them out. So you have to write a lot of letters.

And I think the whole system is too complicated. They need to set up some sane method of processing these bills so that you don't get all this duplication and confusion. I would like to see that happen.

Thank you.

Mr. TAUKE. Let me just, on behalf of all of us I'm sure, extend to you our sympathy on your loss of your wife, and thank you for your observation. I think it does take a Philadelphia lawyer to work through these things.

Mr. PATTERSON. It sure does.

Mr. TAUKE. Yes, sir.

STATEMENT OF LLOYD JEVANSON, CORALVILLE, IA

Mr. JEVANSON. I'm Lloyd Jevanson from Coralville, Iowa. And am on Medicare. And I'd like to address myself, Congressmen, to some concern that I have that all of our energies and all of our thrusts and concern this morning have been concerned with how can we pay for whatever is offered as the cost. I'm wondering if Congress shouldn't spend some time and effort in trying to reduce the cost, or at least hold the line. It's staggering to hear that our costs have gone up from less than tens of billion dollars to $30 billion, and anticipated to be who knows how many billions of dollars.

First of all, I'm a person who's had two parents that are deceased in just the last years. I have one person who is in the hospital and was scheduled for surgery, just an alarming cost surgery, and it was aborted at that point, and the family was told that tomorrow he would have to be removed from the hospital and be in the home. And at that point, our family tried to scramble for hospital beds and utensils and what have you, not knowing what to do or how to care. Thank goodness someone was there that did have some expertise and could help.

So in seems to me that in cases like that if you want to reduce costs, you must provide for some kinds of services, probably more complete service than we have now, and maybe by some specialized medical people—not necessarily a doctor, not necessarily a nurse—but someone who could come in to the home of the gentleman we've just spoken to, and provide some comfort and some security and some ideas as to how to handle a person in those situations.

My other parent was 2 years in a nursing home and at a time when, really, there was no hope for the family. And at this time we observed all kinds of tests being given, which seemed to be completely irrelevant. I asked the people at the nursing home why these tests were given; she couldn't tolerate them, didn't know why—the nursing home said that we have to protect ourselves, and the doctor has to protect himself. I would suggest that if that's why the tests are being given, and the cost given on to Medicare, can't Congress do something about these ridiculous lawsuits which do nothing to improve the quality of medical services, but do everything to destroy the cost?

I'm also concerned with the mention in the material we received this morning where Congressman Fawell indicated that his concern is that the new program will provide an opportunity for ridiculous and some practices of surgery and what have you at the cutting edge level and be ridiculous in cost services that will be offered through the new program. And maybe that is something that ought to be considered.

My concern is that maybe we should invite and give all of the medical profession and find out whether or not there is a better way to offer the services that are needed, and can they be offered at a lesser cost?

Mr. TAUKE. Thank you.

STATEMENT OF HOWARD SILVERMAN, WYOMING, IA

Mr. **Silverman**. My name is Howard Silverman, I'm from Wyoming, Iowa. I'm probably going to say some things today that many here will disagree with, or maybe will not like to hear what I am going to say.

I've written President Bush and you, Congressman Tauke, and our other Representatives in the Congress and I appreciate your answer that you gave me.

Medicare is not cheap. I have a private health insurance policy that gives better protection than Medicare A and B and Catastrophic Care that you currently are going to be funding this year. Our premiums run about $285 less than what is paid for Part A, Part B and what the recipient pays for Catastrophic C. If you want to call it C. We have a less deductible for hospital care and since we pay $100 deductible, I believe currently Part A is about $560.

I don't want Part A, but unfortunately Social Security—since a small portion of my retirement fund is Social Security, I am required to be a recipient of Part A.

Now in addition, our policy gives a $4 million catastrophic care protection to us. Unfortunately it, like Medicare today, does not provide necessary protection for what people require in nursing homes and at home.

Now, we've been screaming about the older people paying for this protection. There also is unfair distribution of costs within the elderly. And to show you how bad it is, I would like to give you examples of three couples. One who lives entirely on Social Security, makes $1 less than $25,000; one who makes all her income on Social Security and makes 2 cents more, 25,000.02. And another couple who have saved during their lives through company annuities or insurance annuities, and they are paying 100 percent taxes on all of their income. Let's look at what Couple A has to pay right now in 1989. Couple A pays no Federal Income Tax, therefore it pays no surcharge for catastrophic care. Couple B, who makes 2 cents more, pays $362 in Federal Income Tax and $54 surcharge. And Couple C who really gets hurt pays $2,239 in Federal Income Tax and pays $336 surcharge.

And by 1993, this percentage jumps to 28 percent surcharge. Couple A still pays nothing; Couple B pays $110 and Couple C pays $629. All three are making within 2 cents of each other in total income.

Now, if Mr. Johnson from Mr. Roosevelt's Committee, says that about 40-some percent of Iowans pay or will be paying this surcharge, the data that I have is slightly less than that. I say that about 30 to 35 percent of the people in this—that are over 65 who will be paying this surcharge, while the other 60 to 80 percent are going to have a free ride.

There's something here which is called a sacred cow. And it happens to be Social Security. I could talk about what I think about Social Security, but I'll skip that since it's really not pertinent to this discussion today.

I have some suggestions: Number one, I think is that this catastrophic care should be a separate program and paid—or not say paid, but should be say kept Part C of Medicare so that it could be chosen by the individual, whether he wishes to have it or not, and not have to pay Part B to get it. And as I said, it should be distributed more equally over all the people aged 65, it has to be all the people who are elderly. The recipients should pay a larger part of the premium and all people over 65 should help pay for it. The Federal Government and the IRS has the information on what everybody makes on Social Security, what everybody gets on annuities is sent by life insurance companies, by employers or previous employers, and it's there, available. And all we need is a supplemental form on which everybody sends money to pay for this catastrophic care. And I think everybody over 65 should be able and should help pay for it. But give everybody over the amount which is deductible or is part of our exemptions on income tax, which is approximately $10,000. And that puts us about at the poverty level of a family of four, not a couple of two.

And I think that pretty much—other than I agree with many of the suggestions that nursing home care and home care probably are the most important things to be covered. Neither my private policy nor Medicare currently adequately covers these programs.

And finally, I'd like to conclude with a saying that Sir Winston Churchill used during World War II, and so you won't think I plagiarized I've just actually changed it slightly to fit this case. "Never in the history of American taxing has so few been taxed so much, to the benefit for so many, but still have the beneficiaries received so little."

And that's pretty sad. With that, I thank you.

Mr. TAUKE. Yes, sir.

STATEMENT OF HAROLD NEEDHAM, EL GATOR, IA

Mr. NEEDHAM. I'm Harold Needham from El Gator, Iowa. I have a concern that has been partly touched on. I did what a lot of people did, sheltered some money, and find out I'm paying more taxes when I try to get out than I sheltered in the first place. But that's beside the point.

I have coverage, supplemental policy, which my wife and I pay $1,300 a year apiece, $2,600 a year for it. We're walking a tightwire though on this whole business, because as I—we will get very little out of this because our's does pay 80 percent of all costs including prescription drugs. But anytime my former employer decides to get out of that policy, I'm automatically out of my insurance.

Secondly, as the government through Medicare starts paying more of this bill, I don't know what my insurance company is going to do. First of all, they haven't chosen to reduce my rates at all. But I'm wondering if these companies are not large enough, if when a number of people start dropping them saying "I can't afford to pay that kind of money when Medicare is going to charge me extra," I'll just drop this insurance and take one of these cheap ones that I see on T.V. for $30-some a month. And we don't have the privilege that we used to have. Once you get out of these, you're out of them. Or once the company decides hey, we're going to get out of this, I'm out of insurance. Or once the government crowds themselves in here and causes me to drop my insurance or my insurance company to drop me and the government decides hey, this is costing way too much money let's get out of the program, I'm going to be sitting without any insurance. In other words, I say I'd like to take care of myself, and I thought I could when I started doing all of this saving throughout my life. But at this point, I suddenly discover that I don't have any control over anything.

And I'm wondering if the people that passed this bill did any consulting with insurance companies, because I can't find a single insurance company that says well, sure we're going to have our costs reduced there we're going to reduce your policies. They all seem to say hey, we're going to keep right on going. And going means going up.

Thank you.

Mr. **Tauke**. I went through the same discussion with my dad over breakfast last Sunday, and he was asking me the same questions. I didn't have very good answers for him either.

Yes, sir.

STATEMENT OF LAUREN PEETE, CEDAR RAPIDS, IA

Mr. **Peete**. I'm Lauren Peete, Cedar Rapids, Iowa. This probably doesn't have so much to do about the catastrophic insurance.

Here's a question I'd like to ask. I was in World War II and a few years ago I wasn't feeling so good, and I went down to Iowa City. They discovered I had cancer of the prostate. They took it out, and I was supposed to go back the 25th of December. I get a telephone call, as long as I wasn't service disability or anything, they told me not to come back.

I've had a brother-in-law who was in World War II, he went in on D-Day, he was all through the Bulge and in Germany, he was never hurt. He can't even go down to Iowa City for anything.

Here's what I want to know: When the Representatives and Senators get hurt or go to the hospital, if they go to Walter Reed or any hospital, who pays their bill?

Mr. **Tauke**. I don't really know since I've never done it. I guess that we have—we pay a health insurance policy and I think the first portion or the first claim would be against that health insurance policy that we have. I presume if there is any extra bill though it's picked up by the taxpayers. I don't know; do you know, Harris?

Mr. **Fawell**. I don't know. I have my own policy, my own health coverage. I've fortunately been in such good health that I haven't had to ask that question. Whether or not I would be entitled to go to Walter Reed if something serious came along, I don't know. I would, personally myself, just continue to use the policy I've had for a number of years. I wouldn't go to Walter Reed; I'd use my own local hospital and physician services.

Mr. **Peete**. Here's another question I want to ask. I went back down and had an examination down to the hospital. They found out I had a tumor where my prostate was at. Well, you know what they did then; they took my testicles out. And I've had bone scans. I can't even go back down there for another bone scan. Now, I know those things cost money. So I'll probably have to go have a bone scan. I had cancer cells all through my rib cage and all through my pelvis. And the last bone scan they give me down there, everything was clear. I asked the doctor, I said, "When is that liable to come back?" He says, "Who knows?" And I sure don't. And it sure kind of makes that hair go gray. Thank you.

Mr. TAUKE. First of all, sir, if you could leave your name with one of my staff people over here I'd like to check into that situation that you just described. I was down in Iowa City a few weeks ago to meet with the administrator and the chief of physicians down there to talk about some of the problems with the VA benefits. And let me just assure all the Veterans here that anybody who has an urgent medical need, can go down to the VA Hospital and receive that, that that urgent medical need will be met. Now, they won't give you ongoing outpatient care or access to pharmaceutical services unless you meet the various criteria that you indicated. But if you have an urgent medical need, they will take care of that.

But, Anne or Dan, could you get over and get that gentleman's name and address? Thank you.

Mr. PEETE. Thank you.

STATEMENT OF GEORGE EVANS, MARION, IA

Mr. EVANS. Representative Fawell, my name is George Evans; I am from Marion, Iowa. I have one simple thing that I would like to add to this, if I may.

In-home care versus long-term care. Long-term care is the most needed thing that we have before us. But, that in-home care would be used prior to the nursing home confinement. The person would be more happy in their own environment. It would be done at a much less cost. The point that I'm trying to make is this: Let's don't put it home care versus long-term care, let's make it a combination. Thank you very much.

Mr. FAWELL. Thank you, sir.

STATEMENT OF MAUREEN TITTLER, ALBERNETTE, IA

Ms. TITTLER. I'm Maureen Tittler from Albernette, Iowa, and I have worked in the health care industry for about 15 years and I have some observations that I'd like to make.

First of all, we're spending almost 12 percent of the gross national product on health care and so I think our Nation is in dire need of revamping our health care system.

Secondly, I'd like to encourage you to look at cost containment and fit it within this bill. When Medicare was passed in 1965, that was not done. And now we're living with DRG's, which in my estimation have not been successful because of two reasons: First of all, larger urban hospitals are making some money on DRG's while small rural hospitals are closing; and secondly, the quicker-sicker scenario is going on and people are going home not knowing how to take care of themselves.

I concur with other people that we should not be forced to choose between home health care and long-term custodial care. I'd like to urge you to look at things like community care centers where people could take their parents during the day so that they could maintain some kind of employment to help pay for costs.

I'd also urge you to reassess, as many people are urging you to reassess, the financing of the bill but not to throw out the good components that are in that bill, like the spousal impoverishment component.

Thank you.

Mr. **Tauke**. Ma'am? You indicated you're in the health care profession. In what capacity, if I might—

Ms. **Tittler**. I'm a nurse.

Mr. **Tauke**. I see. Thank you.

Thank you very much.

STATEMENT OF MARY POLANCE, CEDAR RAPIDS, IA

Ms. **Polance**. Mary Polance, Cedar Rapids. I didn't come today to address the Catastrophic Health Plan; I came mostly to talk to you, Senator, on a one-to-one basis about what's wrong with Medicare, their rules and regulations and so forth. I'm kind of on a one-woman crusade. But as I sat and listened, I decided I had to make two points. One, if you go back and revise this bill, please have people there who know what they're talking about. Because I feel this is part of what's wrong with all these rules; that whoever set them up didn't have any notion of what they were doing. Number two, please don't forget who's most important. Not the government, not the physicians, not any providers of health care, but the patient. And please remember that. Thank you.

Mr. **Tauke**. Thank you.

Yes, sir.

Voice. Good morning. Representative Tauke, I think you're doing a marvelous job.

I'd like to make a few remarks upon—and go back to the founding of our country, of which we've always prided ourselves upon individual freedom. And I have a feeling that all of that individual freedom, what George Washington fought and bled for, is slowly ebbing away. A couple days ago I made a decision to purchase a new piece of amateur radio equipment. Now, I find that if I go through with this, I may find myself in a Federal penitentiary. Because the funds for that need to be sent to Washington, not to amateur electronic supply.

Another point that I would like to make, I spent about 19 years of my life in a data processing center. I was only a janitor, but I have an understanding of computers. When you put Medicare patients on the computer and use that as a means of monitoring pharmacies and doctors and whatnot, should our form of government ever change and we should ever get some nut like Hitler come to our country and we're all human beings, nobody say it can't happen here, all that information would be available on tape for anybody that might decide that elderly may be death, have euthanasia. So they would have everybody, and know where you are, where you live, and all about you. And that is exactly what is going to happen.

So therefore I'm asking you, friends, to think not so much about care from cradle to the grave as your own personal life and freedom.

Goodbye.

Mr. TAUKE. Thank you.

We're running late so these will be the last two individuals; those two that are standing there now.

STATEMENT OF WILLARD CLAY, CEDAR RAPIDS, IA

Mr. CLAY. Thank you. My name is Willard Clay, I'm from Cedar Rapids. And I'm president of a local unit number 29 of the NARBRE, National Association of Retired and Veteran Railway Employees, of which we have several units, probably 150 or so, throughout the United States.

Of course, there is a lot of dissatisfaction, I think it's well understood by possibly maybe not so much the general public but those knowledge of our concerns, retirees, of what we feel is not the wisest structuring of our railroad retirement into the Social Security. We certainly don't want the two combined and we have reservations, of course, as to bringing the taxation, the IRS provisions, applying to the railroad retirement as to the Social Security.

In addition, I don't know that I can say too much to add to what has been said. There are statements that have been well put. But I'm concerned why optional coverage of provisions of Catastrophic Health Care, Medicare, and so forth, couldn't be enacted and have a wider source of contributions to support these. Now, in our particular situation the M.D., the medical coverage has been pretty substantial. But there comes a time when chiropractic services could be of a great advantage. Now, I've never been to a chiropractor in my life but I do see benefits from this and I'm wondering why more emphasis can't be placed in this respect. It is applied to osteopathy as far as I know and I don't know whether one of you gentlemen can answer the chiropractic provisions or not. Tom or Mr. Fawell.

Mr. TAUKE. Congress has to make a judgment each year of what services will be covered. I am one of those who favors covering chiropractic services, but it's a matter—it comes up for a vote virtually every year in our subcommittee.

Mr. CLAY. Now, is that currently covered, chiropractic treatment?

Mr. TAUKE. I'm trying to remember exactly where we are on covering chiropractic. I know we cover it to some extent, but I don't know if we cover it the same as medical services or not.

Mr. CLAY. Well, in our particular situation this is—pardon me.

Mr. TAUKE. Let me call on our expert here to answer that question.

Mr. TILGHMAN. The current coverage of chiropractor service under Medicare is very limited. We'll pay only for suplaxation of the spine, which is a very limited diagnosis for chiropractic care. It also has to be documented by an X-ray that shows that there is in fact a suplaxation of the spine. We will not pay for the cost of an X-ray unless it's provided by an M.D. however. So it is covered, but only very, very slightly under current Medicare policy.

Mr. CLAY. In other words, as to what the X-ray would reveal. The treatment in that respect, right?

Mr. TILGHMAN. Yeah. Only for one very specific and very limited diagnosis.

Mr. CLAY. Okay, diagnosis. But this could be a chronic situation, though.

Mr. TILGHMAN. For example, if you just have lower back pain you can't go in and see a chiropractor and get that covered. You have to have a diagnosis of suplaxation of the spine, which I can't define for you right now. Maybe the nurse could define it better than I could here. But it has to be that specific diagnosis or Medicare won't pay anything for any chiropractic care.

Mr. CLAY. I see. Thank you.

I believe that pretty well sums up my concerns there. Thank you very much, Representative Tauke and Mr. Fawell.

Mr. TAUKE. Thank you.

STATEMENT OF GEORGE CLANE, DUBUQUE, IA

Mr. CLANE. George Clane, Dubuque. It's my understanding that the Medicare program started originally as an insurance program. This all of a sudden has changed into a welfare program, in my opinion. I wonder what the Congress, our Congressmen would say if private insurance carriers all of a sudden adopted this same policy. I don't—I think that they would probably holler fraud, fraud, fraud and then some. So it seems that government can do certain things that somebody else cannot do.

Secondly, I'd just like to say that I appreciate Tom Tauke's efforts not only for the Notch problem but for this catastrophic health problem. He seems to have more smarts than even our honored AARP people who promoted the program. When they didn't—and I think Tom deserves credit for the efforts that he's made for this, and should he make a run for the Senate, I hope he gets the support of everybody. Because he certainly has been doing a good job.

Mr. TAUKE. Thank you. Well, that's very kind of you to say but we're just trying to do the job here this morning of getting information out about a policy that is of great concern to individuals to across the State.

I want to make a couple of observations. First is that if anybody has any information that they want to share with us or they are thinking about things about this hearing and want to share some additional views, if you will send those views to my office we will include it in the record of the hearing, as long as receive them within the next 2 weeks. So if you have additional views that you want to send, send them to our office and we will include them in the record as long as we receive them in the next 2 weeks.

Secondly, if there are problems or concerns that you have about your own ability to get coverage under the Medicare bill—or Medicare program—and if you are from time to time having problems in receiving those benefits, don't hesitate to be in touch. We have offices in Dubuque, Cedar Rapids and Clinton, or just write and we have—we will try to work with you to make sure that any problems that you're having with Medicare are resolved in a fair way for you.

Other than that, I wanted to thank the Teamsters for permitting us to use this facility. I want to thank Congressman Fawell for his participation. I want to thank all of the witnesses for their outstanding contributions, and finally thank all of you for coming.

[Whereupon, the hearing was adjourned at 12:46 p.m.]

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